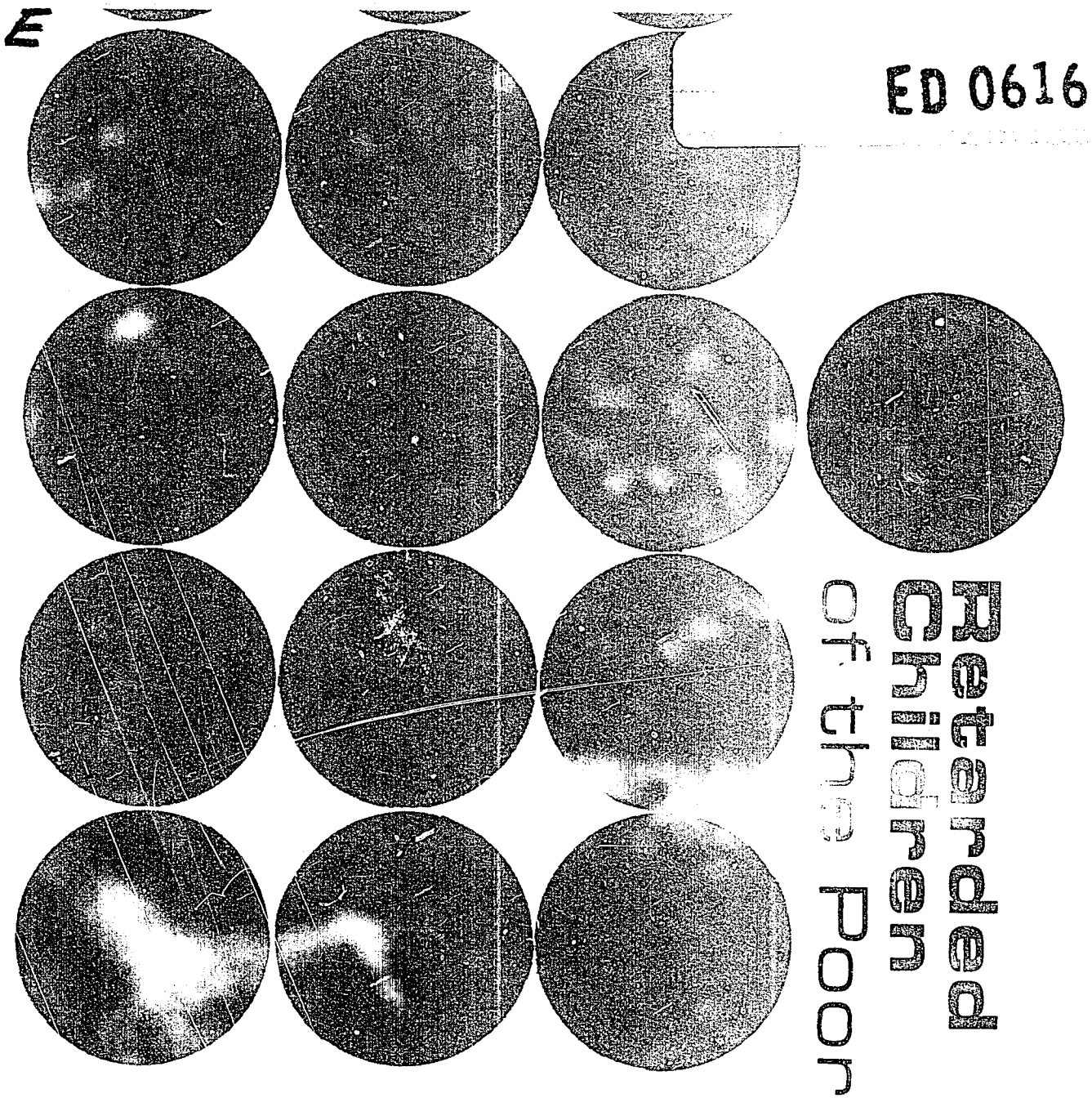
DOCUMENT RESUME

ED 061 667 EC 041 666

AUTHOR	Kirkland, Majorie H.
TITLE	Retarded Children of the Poor: A Casebook.
INSTITUTION	Community Services Administration (DHEW), Washington, D.C.
REPORT NO	SRS-72-23003
PUB DATE	71
NOTE	71p.
EDRS PRICE	MF-$0.65 HC-$3.29
DESCRIPTORS	Disadvantaged Groups; Educable Mentally Handicapped; *Exceptional Child Services; Family Counseling; *Family Problems; *Lower Class; *Mentally Handicapped; *Social Services; Social Work

ABSTRACT

Written for welfare and social workers, the publication concerns families which have problems of retardation, usually mild or borderline, and which are heavily represented on welfare rolls. A brief discussion of retardation and family and child welfare services is followed by a list of suggested readings dealing with social and child welfare services applicable to the retarded. The remaining six chapters are each introduced by a summary of a typical problem case of retardation: a school-age boy, an adolescent girl with normal siblings, a rebellious adolescent boy in foster care, a case of dependency resulting from institutional living, an adult in need of vocational training, and a family with several mildly retarded children. Discussion following each case presentation focuses on understanding of the family situation involved, analysis of problems represented by the case, and suggestions for the social worker concerning assistance and services which can be provided to clients to ameliorate such situations. (KW)



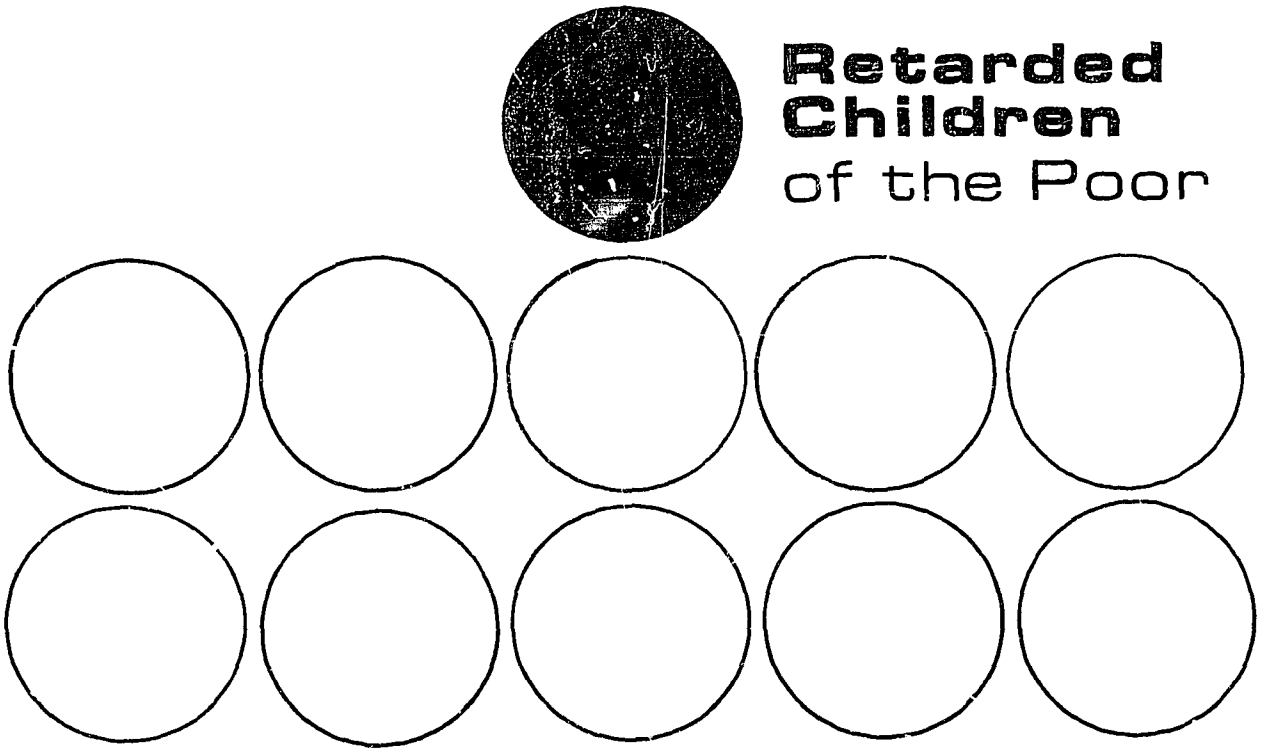
Retarded Children of the Poor

a casebook

"It has been said that the constitutional mandate of equal protection under the law requires that 'all persons . . .shall be treated alike, under like circumstances and conditions, both in privileges conferred and in the liabilities imposed.' Sometimes it is apparent that some specific factor is needed to provide equal treatment for the unequally endowed . . . . If height is an advantage, the short man may at least be given a box to stand on."

David L. Bazelon
Chief Judge
United States Court of Appeals
for the District of Columbia

Quoted from: *Report of the Task Force on Law* to the President's Panel on Mental Retardation (David L. Bazelon and Elizabeth M. Boggs), January 1963.



Retarded Children of the Poor

a casebook

Majorie H. Kirkland, M.S.S.W.

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL and REHABILITATION SERVICE ● Community Services Administration

DHEW Publication No. (SRS) 72-23003

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Mrs. Kirkland, formerly with the Division of Child and Family Services of the Children's Bureau, prepared this publication prior to the Bureau's reorganization in 1969. At that time, the Division became a part of the newly created Community Services Administration.

FOREWORD

Retarded persons of all ages may be found in families receiving social services. Some may be severely handicapped, both physically and mentally. A greater number, however, will show only mild degrees of intellectual handicap, but will present a wide variety of behavioral and social problems.

In the past, workers have had limited choices among resources for helping the retarded. If the handicapped person could not be relatively easily managed in his home, the only solution was commitment to a State institution for the retarded.

Now, however, a great variety of programs and services are being or have been developed. Some are specifically for the retarded, such as special classes, day care centers, and workshops and activity centers for adults. Others are services which are available to all who need them regardless of intellectual proficiency, such as foster family care, medical and dental services, and homemaker services.

Furthermore, almost every community has access to a clinic for the diagnosis and evaluation of persons suspected of being retarded. This broadening array of services imposes on the welfare worker the responsibility for making carefully worked out plans to suit each individual case. This responsibility, in turn, requires that the worker have a basic knowledge of recent findings which have led to the present emphasis on community programing for retarded persons of all levels and ages.

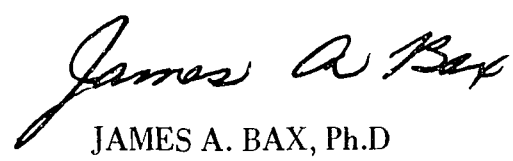
This publication deals with families that have problems of retardation, and are heavily represented on welfare rolls: the mildly and borderline retarded, whose appearance and behavior are usually not grossly different from the "normal," but whose behavior is often frustrating to the worker.

The basic information about the whole range of retardation—its causes and effects—may be found in a publication published by the Children's Bureau: *The Mentally Retarded Child: A Guide to Services of Social Agencies*, by Michael J. Begab.

As workers become more familiar with retarded persons, they will come to realize that the retarded share with other people the need for love, identity, understanding, a purpose in life, the satisfaction of accomplishment.

The ways in which these needs are met may be different in timing or in setting. This publication points out the similarities in human needs, and some of the differences in methods of achieving them.

It is hoped that this publication will be of practical use to workers, supervisors, and others concerned with helping the retarded child and his family, especially at this time when a broad program of individual and family services is being developed.



JAMES A. BAX, Ph.D
Commissioner
Community Services Administration

CONTENTS

RETARDATION AND FAMILY AND CHILD WELFARE SERVICES

Mentally retarded children have long been included in family and child welfare service caseloads on the basis of dependency and neglect. Now, welfare agencies are being pressured to include retarded children when their presence in the home poses a threat to the integrity of the family. It has been urged both in the popular media and the professional literature that mentally retarded persons be served not only by facilities developed to meet their special needs, but also by agencies which have not heretofore considered the retarded, per se, as their clients. Family and child welfare service agencies are now recognizing their responsibility to plan programs which take into account not only the needs that the retarded child shares with other children, but also the special social service needs he has which are related to his handicap.

A strong deterrent to more aggressive efforts by welfare agencies to serve this group is the attitude that the condition of retardation is static, with no real hope of improvement. It is not surprising that many people have this attitude; it was the belief held for many years not only by laymen but also by many professional workers in the field of mental retardation. The fact is, most retarded children can be helped to improve their functioning, and retardation can be prevented in some instances. Some of the most dramatic advances have been medical, but substantial gains have also been made in other areas. New understanding, more specific techniques, and more effective programs have been developed in the fields of education, psychology, and nursing, as well as in social work. Much more needs to be learned about retardation and the retarded, but what is already known needs to be put into practice.

Seventy-five percent or more of persons identified as being retarded come from "culturally deprived" families—families who often represent the second, third, or fourth generation living at the bare subsistence level. Cases of severe retardation with obvious physical abnormalities occur among the children of the very poor at a rate at least equal to that of the general population. But children with mild retardation stemming from a cause which cannot be determined on a physiological or neurological basis usually come from the lowest socioeconomic groups.

Socioeconomic level, education, health, personality dynamics, interpersonal relationships, and intellectual functioning are interrelated in a complex spiral of mutual reinforcement that has been well documented. Lowered

intellectual functioning certainly makes the solutions to the problems posed by financial insufficiency more difficult, works against greater educational achievement for the next generation, is likely to mean less constructive handling of health problems, and so on, each result causing further problems.

Problems growing out of a complex of causes are not likely to be solved by concentrating on a single cause. Nor are the various methods of intervention within the province of a single discipline. Physicians, educators, economists, social workers, cultural anthropologists, sociologists, psychologists, and many other professionals must contribute their knowledge and skills. The social worker who tries to do the whole job, even with a single family, is almost certainly doomed to failure. A vital part of her task is the enlistment of and cooperation with all the other individuals and agencies that can help the family.

At the same time, interpersonal and other social aspects of both poverty and retardation affect all the other aspects, just as the social aspects are affected by them. Consequently, improvement in social functioning will increase the chances for improvement in other areas.

Since the caseloads of family and child welfare service agencies are heavily weighted with children of families in poverty, social workers in these agencies are likely to find themselves dealing with problems related to mental retardation in a large number of families. Even if the principal client is not retarded, a retarded sibling, parent, or other relative may present significant family problems.

Once some of the connections between poverty and retardation are realized, the importance of social services in relation to the retarded becomes clear. Workers not only can provide service to children and parents known to be retarded, but they can also bring timely help to many others by being alert to signs of possible retardation and to conditions that can lead to retardation. They can help arrange for examinations of children they think may be retarded. They can work with individual professionals, clinics, schools, and training and recreational facilities to help meet the needs of the children for evaluation, treatment, and other services.

Agencies, however, have not always been successful in their efforts with or on behalf of the retarded. Communication with the client is often difficult. Resources are usually limited. The attitude that the retarded cannot be helped to any meaningful extent is not uncommon. It is difficult to find help in the literature on working with deprived retarded children and their parents, though there is much on counseling the middle-class family.

Although welfare agencies need help in working with and on behalf of retarded children of all degrees of retardation, in various socioeconomic groups, the most pressing need is probably for help in dealing with the mildly

retarded who are without demonstrable organic defect and whose families live in conditions of severe deprivation. Workers need help in understanding why a parent does not follow up on the opportunity to have his child examined; in interpreting to the foster parent the behavior of the school-age retarded child; in talking with the child himself or with his teenage sibling who is dropping out of school and into trouble; and in dealing with the retarded parent.

This casebook is intended to help meet these needs. It is written for the use of the inservice trainer, whether he is assigned full time to inservice training or is a supervisor who works with learners individually or in small groups.

Each case is introduced with the caseworker's or intake worker's summary. Various types of cases are presented to help widen the learner's understanding of families affected by cultural retardation. The case summary is followed by "Teaching Points"—a discussion of certain factors to which the caseworker must be alert or should follow up on, possible interpretations of the behavior and conditions described, and actions which might be considered.

Although this casebook deals with types of situations that are particularly problematical for welfare agencies when they occur, it is basically intended to emphasize the need to consider and treat each child who is retarded, or suspected of being retarded, individually. A recurring theme is the necessity for thorough evaluation—medical, psychological, social, vocational, etc. Only when each child's particular qualities are recognized can the goal of helping him make the most of his strengths be effectively pursued.

No attempt is made in this casebook to cover the general information that trainees should have about mental retardation and about characteristics of poverty in America. For such information, there are many sources available. Of particular value are Begab's *The Mentally Retarded Child: A Guide to Services of Social Agencies* and Irelan's *Low-Income Life Styles.*

SUGGESTED READINGS

Anderson, Alice V.: "Orienting Parents to a Clinic for the Retarded." *Children,* September-October 1962, pp. 178-182. Reprint available from the Maternal and Child Health Service, Health Services and Mental Health Administration, U.S. Department of Health, Education, and Welfare, Rockville, Md. 20852.

Describes how parent group meetings can be used to increase the parent's understanding of the child's problem.

Arnold, Irene L. and Goodman, Lawrence: "Homemaker Services to Families with Young Retarded Children." *Children,* July-August 1966, pp. 149-152. Reprint available from the Community Services Administration, Social and

Rehabilitation Service, U.S. Department of Health, Education, and Welfare, Washington, D.C. 20201.

Describes the results of a 3-year project conducted by two voluntary New York City agencies to demonstrate the potential contribution of homemakers in helping families of the retarded cope with situations of stress and in preserving the family structure.

Beck, Helen L.: "Casework with Parents of Mentally Retarded Children." *American Journal of Orthopsychiatry*, October 1962, pp. 870-877. Reprint available from the Community Services Administration, Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare, Washington, D.C. 20201.

A case history is used to demonstrate casework treatment with families of mentally retarded children.

Begab, Michael J.: *The Mentally Retarded Child: A Guide to Services of Social Agencies.* Children's Bureau, U.S. Department of Health, Education, and Welfare, 1963, 134 pp. Available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Price: 45 cents.

For social workers in practice and in training. Includes information on characteristics of retarded children, family-related problems, techniques and methods of casework and social group work.

Begab, Michael J.: *The Role of Child Welfare in Mental Retardation.* Children's Bureau, U.S. Department of Health, Education, and Welfare, 1961, 13 pp. Available from the Community Services Administration, Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare, Washington, D.C. 20201.

Examines the role of child welfare in providing a broad spectrum of services for the mentally retarded, including prevention, care, treatment, and community planning.

Braik, Adeline: "Public Welfare Serves the Mentally Retarded Child." *Public Welfare*, April 1967, pp. 110-115. Reprint available from the Community Services Administration, Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare, Washington, D.C. 20201.

Describes the efforts of the Services to Retarded Children Unit, Florida State Department of Public Welfare, to spare retarded children unnecessary institutional care by working with the families or placing the children in foster homes.

Dittmann, Laura L.: *Children in Day Care, with a Focus on Health.* Children's Bureau Publication 444. U.S. Department of Health, Education, and Welfare,

1967, 120 pp. Available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Price: 50 cents.

Identifies principles for guiding the healthy development of children in daytime programs. Fundamental problems which still persist are pointed out. The special needs of various ages and groups of children are examined in some detail.

Dittmann, Laura L.: "The Family of the Child in an Institution." *American Journal of Mental Deficiency*, March 1962, pp. 759-765.

Discusses the factors which may make it difficult for parents to maintain or develop meaningful ties with a retarded child living in an institution.

Dittmann, Laura L.: *The Mentally Retarded Child at Home: A Manual for Parents.* Children's Bureau Publication 374. U.S. Department of Health, Education, and Welfare, 1959, 99 pp. Available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Price: 35 cents.

Offers practical information to parents about day-to-day care of retarded youngsters, including suggestions on toilet training, dressing, discipline, speech, play, and school.

Franklin, Owen E. "Serving the Mentally Retarded." *Public Welfare.* October 1965, pp. 281-284. Reprint available from the Community Services Administration, Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare, Washington, D.C. 20201.

Directs attention to the needs of the mentally retarded and the responsibility of public welfare to help promote the development of a continuum of services.

Gallagher, Ursula M.: "The Adoption of Mentally Retarded Children." *Children*, January-February 1968, pp. 17-21. Reprint available from the Office of Child Development, U.S. Department of Health, Education, and Welfare, Washington, D.C. 20201.

Emphasizes that adoptive placement is feasible for many retarded children and identifies several considerations of importance in such placements.

Historical Perspective on Mental Retardation During the Decade 1954-1964: A Compilation of Articles in CHILDREN. Children's Bureau, U.S. Department of Health, Education, and Welfare, 1964, 314 pp. Available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Price: $1.75.

The articles vary widely, from one portraying the reaction of a mother to her retarded child to a series directed to the highly skilled professional worker.

Irelan, Lola M. (Ed.): *Low-Income Life Styles.* Soci and Rehabilitation Service, U.S. Department of Health, Education, and Welfare, 1968, pp. Available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Price: 35 cents.

The essays cull the salient findings of many studies of low-incor life styles. They deal with the outlook on life, family patte , educ ion, health practices, and consumer practices.

Jaslow, Robert I.: *A Modern Plan for Modern Service to the Mentally Retarded.* Division of Mental Retardation, Rehabilitation Serv Administration, Social and Rehabilitation Service, U.S. Department of He , Education, and Welfare, 1967, 12 pp. Available from the Division.

Statement of the basic philosphy of the Division of Mental Retardation concerning the provision of services to the retarded residing in a community.

Kirkland, Marjorie H.: "Institutions for the Retarded: Their Place in the Continuum of Services." *Mental Retardation,* April 1967.

Considers advantages and disadvantages of institutional placement for retardates of varying levels of ability. Currently held assumptions about benefits for mildly and moderately retarded individuals and automatic placement of severely retarded are challenged.

Kramm, Elizabeth: *Families of Mongoloid Children.* Children's Bureau Publication 401. U.S. Department of Health, Education, and Welfare, 1963, 56 pp. Available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Price: 25 cents.

Report of a study of 50 families who had a mongoloid child living in the home. It highlights, in the words of the parents, the problems they had, what they did or failed to do about the child, and what their ultimate adjustment has been.

Kugel, Robert B. and Parsons, Mable H.: *Children of Deprivation: Changing the Course of Familial Retardation.* Children's Bureau Publication 440. U.S. Department of Health, Education, and Welfare, 1967, 86 pp. Available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Price: 35 cents.

The report of a 5-year project designed to (1) record in detail the growth and development of a group of children with familial mental retardation, and (2) alter the unfavorable course of their development by enriching many aspects of their personal lives, their homes, their schools, and their communities.

Mackie, Romaine P.: "Opportunities for Education of Handicapped Under Title I, Public Law 89-10." *Exceptional Children,* May 1966, pp. 593-598. Reprint available from the Office of Education, U.S. Department of Health, Education, and Welfare, Washington, D.C. 20201.

Explains how Public Law 89-10 and its amendment, Public Law 89-313, provide financial assistance for programs for handicapped children.

The Mentally Retarded. . .Their New Hope. President's Committee on Mental Retardation, U.S. Department of Health, Education, and Welfare, 1966, 20 pp. Available from the Committee.

This booklet is part of a national campaign to inform the public about the scope of mental retardation and what must be done to assure the mentally retarded their rightful place in society.

Schreiber, Meyer and Feeley, Mary: "Siblings of the Retarded: I - A Guided Group Experience." *Children,* November-December 1965, pp. 221-225. Reprint available from the Community Services Administration, Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare, Washington, D.C. 20201.

Describes the findings of a group discussion demonstration conducted for selected normal adolescents to assist them in clarifying their role as siblings of a retarded child.

Whitman, Pearl S. and Oppenheimer, Sonya: "Locating and Treating the Mentally Retarded." *Social Work,* April 1966, pp. 45-52. Reprint available from the Maternal and Child Health Service, Health Services and Mental Health Administration, U.S. Department of Health, Education, and Welfare, Rockville, Md. 20852.

Results of a survey, conducted by a multidisciplinary clinic, of children under 3 years of age referred by a hospital pediatric clinic. Over 9 percent of the children were functioning at a retarded level, indicating the need for realistic casefinding techniques and periodic reevaluation.

JOHNNY WATKINS
(school-age boy)

OBJECTIVES:
- To deepen understanding of interrelationships among biological, social, and psychological causes of behavior which may suggest mental retardation.
- To enable worker to recognize clues to reasons for reduced scholastic functioning.

INTAKE SUMMARY

Mrs. Watkins came to the office without an appointment. She was neatly though inexpensively dressed. She gave me the impression that she was sickly, and told her story in a rather whining voice.

Her son, Johnny, 12 years old, is repeating and failing the fourth grade in a rural consolidated school. Recently he has been out of school quite frequently. During his first two grades, his attendance was good; during his second year in third grade, he was sick for quite a long time with measles; subsequently he missed a day or two at a time at frequent intervals because of vague illnesses. This pattern continued during his first year in fourth grade. This year, he not only has been absent more frequently, but many times has been unable to produce a written excuse. At first, the teacher accepted his story that he had lost the note. When this became a pattern, however, the teacher got in touch with Johnny's mother and learned that, several times, he was not at home when he said he was sick. When questioned, Johnny admitted that he had played in the woods until time to go home.

At first, Mrs. Watkins did not tell her husband about Johnny's truancy, but had scolded and lectured the boy at length and threatened to tell his father if he missed school again. Finally she felt compelled to tell Mr. Watkins, who then beat Johnny severely.

Mr. Watkins' rough treatment was the reason Mrs. Watkins tried not to let him know when Johnny was in trouble. Mr. Watkins accuses her of spoiling Johnny, but her view is that Johnny isn't very strong, especially since he was sick with measles a couple of years ago.

After Johnny was born, Mrs. Watkins had a couple of miscarriages, and finally a hysterectomy was performed. She has not felt really well since her operation, and, because of this, she thinks she knows better than her husband how Johnny feels. She works occasionally, doing housework for people, but often she does not feel well enough to work.

Mr. Watkins works in a filling station and has a part-time job in a greenhouse. According to Mrs. Watkins, if he worked regularly and brought home all his money, there would be enough for the family to live on, but he often gets drunk on weekends and then doesn't go to work on Monday. Sometimes during the week, too, he gets drunk and doesn't go to work the next day.

Sometimes on payday, he comes home in a good mood and takes the family out for an impromptu picnic or to buy ice cream, or he takes Johnny fishing. Other times, he comes in mad at the world and then—look out! Mrs. Watkins says it doesn't make any difference to him how she feels, or whether Johnny is sick, or what. You have to stay out of his way if he's mad; and you'd better go on whatever trip he's thought up when he's in a good mood. The least little thing upsets him and then he'll start batting Johnny around and threatening to hit her. He has hit her a couple of times, and she has thought of leaving him, but she doesn't have any money, and couldn't earn enough. So she stays out of her husband's way when he's in one of those moods, and tries to keep Johnny away from him, too.

The school has threatened to take the family to court if Johnny is out of school again without a doctor's excuse. Mrs. Watkins can't afford to pay a doctor each time Johnny feels bad, and she is afraid of what Mr. Watkins might do if they have to go to court. That is why she came to us. She wants us to scare Johnny into going to school, without getting Mr. Watkins involved.

The school reported by phone that Johnny is retarded, immature, lazy, and given to all kinds of excuses for not doing his work. He frequently complains of headaches, and the teacher has wondered about his eyes; but his eye examination at school was negative.

He hands in very little written work, and what he does turn in is very carelessly done. He could do better work orally, but in fourth grade so much reading is required that he is not able to keep up. His reading is somewhere on the second grade level, but even at that level he makes many careless errors, such as reading "was" for "saw." And he has not learned to follow with his eyes across a line of type and back to the beginning of the next. The teacher often has to point to the right line for him.

The school feels his mother babies him too much. But they were not able to get her to come in to discuss his failures until they threatened to refer the case to court for truancy. If they thought his family would carry through, they would refer Johnny to the guidance clinic in the nearby town, but they know that this is futile. That is why they are ready to resort to court action.

TEACHING POINTS

Social factors that are common to many types of welfare cases and which need further study will not be discussed here or in other cases, though their importance is tacitly recognized. Only those factors relating intimately to cultural deprivation and to mental retardation will be dealt with.

Question for discussion: What handicaps do you think Johnny might have, in addition to possible mental retardation, that might account for his general behavior in school?

Let us assume for purposes of discussion that Johnny was born with the potential for normal development. We do not know much about his early years: the relationship between his parents and how they related to him; how stimulating his environment was in terms of preparation for school; what his parents valued and what concept they had of him (which would strongly influence his concept of himself). Some of the factors we would look for have been described by Robert Hess. He points out that the way a parent communicates with a child may have the effect of stimulating his initiative, concept formation, curiosity, and feeling of worth as well as more obvious results such as vocabulary and motivation. Two examples of mother-child communication may clarify these effects:

> "Assume that the emotional climate of two homes is approximately the same—the significant difference between them is in the style of communication employed. A child is playing noisily in the kitchen with an assortment of pots and pans when the telephone rings. In one home, the mother says, 'Be quiet,' or 'Shut up' or any one of several short, peremptory commands, and she answers the phone while the child sits still on the floor. In the other home, the mother says, 'Would you keep quiet while I answer the phone.' The question the study poses is this: What inner response is elicited in the child; what is the effect upon his developing cognitive network of concepts and meaning in each of these two situations? In one instance, the child is asked for a simple mental response. He is asked to respond to an uncompli-

> cated message and to make a conditioned response (to comply); he is not called upon to reflect or to make mental discriminations. In the other example, the child is required to follow two or three ideas. He is asked to relate his behavior to a time dimension; he must think of his behavior in relation to its effect upon another person. He must perform a more complicated task to follow the communication of his mother in that his relationship is mediated in part through concepts and shared ideas; his mind is stimulated or exercised (in an elementary fashion) by a more elaborate and complex verbal communication initiated by the mother."[1]

Obviously, for either child, the single experience will have little effect; but when a child habitually experiences brief, uncomplicated, unsubtle communications, he is not being adequately prepared for school where the norm is constant exposure to more stimulating verbal communication.

The literature on families in poverty and on the retarded frequently cites the "non-verbal" character of their communication. It is not that the poor do not talk—though they may use silence, or frustratingly brief replies as a defense against intrusion by strangers. When their defenses are down, they can speak quite fluently, and sometimes even poetically. But verbal communication between them and the middle-class person may be difficult because of their simple vocabularies, the lack of explanatory clauses, and the sometimes disturbing simplicity and directness of their statements. On the basis of a brief acquaintance, a poor or a retarded client may ask bluntly and embarrassingly, "Do you love me?" Not only does the asking of this question show lack of knowledge about middle-class etiquette, but its form indicates the limited vocabulary which does not contain alternate words with slightly different shades of meaning. To these persons "to love" may mean "to like," "to admire," "to like to be with," or "to be concerned about"; "to feel bad" may be the only verbal expression available to communicate hurt, embarrassment, rage, shame, etc.

Such a limited vocabulary not only hampers communication of subtle but important differences but also limits intellectual development.

Another example of the effect of the culture of poverty on a child's preparation for school is given by Hess. A number of mothers from various socioeconomic classes were asked:

> "Imagine your child is old enough to go to public school for the first time. How would you prepare him? What would you tell him?

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[1] Hess, Robert D.: "Educability and Rehabilitation: The Future of the Welfare Class." *Journal of Marriage and the Family*, November 1964, p. 425.

"One mother, who is person-oriented and uses elaborated verbal codes, replied as follows:

'First of all, I would remind Portia that she was going to school to learn, that her teacher would take my place, that she would be expected to follow instructions. Also, that her time was to be spent mostly in the classroom with other children and that if any questions or problems arose, she could consult with her teacher for assistance.'

"...In terms of promoting educability, what has this mother done in this response? First, she has been specific and informative; she has presented the school situation as comparable to one already familiar to the child; second, she has offered reassurance and support to help the child deal with anxiety; third, she has presented the school situation as one which involves a personal relationship between the child and the teacher; and fourth, she has presented the classroom situation as one in which the child is to learn. This orientation toward school fosters confidence and initiative on the part of the child and helps him gear into the school routine by seeing it as an extension of the home situation.

"A second mother responded as follows to this question:

'Well, John, it's time to go to school now. You must know how to behave. The first day at school you should be a good boy and should do just what the teacher tells you to do.'

"In contrast to the first mother, what has this mother done? First, she has defined the role of the child as passive and compliant. Second, the central issues involved in school are in the area of dealing with authority and the institution, rather than with learning. Third, the relationship and roles portrayed are sketched in terms of status and role expectations, rather than in personal terms. Fourth, the entire message is general, restricted, and vague, lacking in information about how to deal with the problems of school except by passive compliance.

"This child...is prepared, at best, to engage in role learning and passive acceptance of school authority in the learning situation. His...participation in the learning possibility of the school is meager, and the teacher who attempts to engage him in an exchange of ideas or tries to encourage him to inquire and to ask questions will soon be frustrated and disappointed. Not that all such children accept the authority of the school in this unquestioning fashion; the point is that the restrictive interaction in the home and in the accompanying verbal exchanges gives them no alternative except to resist and rebel. The range of

choice open to them is limited by the nature of the cognitive and interactional environment in which they have had experience."[2]

Over a period of time, such experiences convey to the child the image of the school as "distant, unresponsive, competent, and authoritarian."[3] The value of "staying out of trouble" is emphasized rather than the value of engagement in learning; the authority of the teacher, rather than her friendliness and guidance; the passive role of the child, rather than the active.

We do not know at present whether the Watkinses reflect their culture in these ways, and we must not act in this area until we do. But knowing that many people think so differently from the way we think may make us more alert to the particular outlook and attitudes of the family under discussion.

We also do not know about Johnny's health prior to the measles; nor can we be sure yet that he has no problem with his eyes. His seeming aversion to writing and reading, his reversal of words when he reads, and his inability, especially at this age, to follow the lines in reading would certainly suggest the need for a thorough vision examination. The chart often used in schools is not adequate to detect certain visual problems.

If Johnny does have a visual problem and it is corrected, he should be referred for a psychological evaluation after he has had time to get used to seeing better. Many psychological tests depend on correct vision, and Johnny might score spuriously low if he were tested before making the adjustment to better vision.

The information we have so far does not indicate how much change there was in Johnny's school progress—aside from his absences—after his bout with the measles. We know that he failed third grade, in spite of adequate attendance, so there was already a problem before the measles. More information about his performance in his first 3 years in school, as well as his early developmental history, will help determine the nature, causes, and effects of his problem(s).

At least three factors may be interacting to impair Johnny's intellectual-social functioning: some possibility of a mild degree of intellectual retardation (which may not be severe enough to label "mental retardation"); a possible visual problem which may have followed his illness or may have caused some of his earlier reading difficulties; and a home situation which is not conducive to healthy social and emotional development. Each factor could feed into the others to increase the degree of total handicap, whereas each alone might not have been disabling.

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[2] See footnote 1, page 12 (p. 427).
[3] See footnote 1, page 12 (p. 428).

One can see, also, the outline of an adjustment mechanism which seems to be developing: the use of illness to avoid unpleasant situations. More evidence is needed, but it may be tentatively supposed that some of Johnny's needs were met during his illness when he was in third grade, and that he has continued to find relief from the frustrations of school through illness. His mother apparently responds to his weakness, so he may develop a pattern of avoiding tension through illness. If further exploration bears out this supposition, casework efforts should be directed toward helping both Johnny and his mother to handle problems more constructively.

It is possible, too, that Johnny's father is somewhat scornful of his son because of his physical weakness. We do not know at this point whether Mr. Watkins can be easily involved in a treatment program for Johnny. Many, but not all, fathers in such families leave these projects to their wives. Methods developed so far for strengthening these families have largely failed to reach the fathers.

Mrs. Watkins' response to Johnny's weakness has a faint middle-class flavor. Whether this is because Mrs. Watkins maintains some ties with a higher socioeconomic background, or because she is defending her own weakness, or because Johnny is her only child (while most such families have several children), we do not know. We do see a response to authority which is fairly characteristic of the deprived group: failure to act until immediate action against the parents is threatened. We also see Mrs. Watkins' tendency to project the blame onto Mr. Watkins and her hope that the agency could scare Johnny into "right" behavior.

LUCINDA PARKER
(adolescent girl with normal siblings)

OBJECTIVES:
- To understand some dynamics of behavior of retarded adolescent girls.
- To deepen understanding of some attitudes toward retardation.
- To understand some values and limitations of institutional experiences.

INTAKE SUMMARY

Mrs. Parker was referred to us by the school. She wants help in getting her 14-year old daughter, Lucinda, into the State institution for the retarded. Mrs. Parker is concerned because Lucinda is becoming interested in boys and "might get into trouble." She has been in a special class since the fifth grade, but Mrs. Parker said she does not know what she will do with Lucinda when she is too old for school because she will not be able to hold down a job. Mrs. Parker feels perhaps it would be best for Lucinda to go to the institution now before problems occur.

After questioning Mrs. Parker and talking with Lucinda, her teacher, and some of the other children at school, I have the impression that Lucinda is not really interested in boys yet, but that boys are becoming interested in her. The main development, however, is that Lucinda is beginning to menstruate.

Lucinda is the fourth of seven children. The others are: Conrad, age 18, who dropped out of school in the 10th grade, could not find a job, and is now in the Job Corps; Mazie, age 16, in the 9th grade but almost a dropout (she is still enrolled, but seldom goes to school), Dorothea, age 15, also in the 9th grade, and doing well (she plans to graduate). Then comes Lucinda. The

younger children are Pete, age 12, in the 6th grade but barely passing; Bob, age 10, in the 4th grade, doing low average work; and Frankie, a girl, age 3, who seems quite normal.

The school reports that Lucinda is a quiet, passive girl, quite pretty and lively. She looks entirely normal. If you watch her for a while with a group of girls, however, you can see that she tends to choose younger girls to play with, and she behaves more like an 11- or 12-year-old. Although she is physically adolescent, she does not seem really interested in boys. Her sisters are "boy crazy," especially Mazie.

Lucinda is in a special class which has both advantages and disadvantages for her. Some of the children "look retarded"—that is, have physical defects or blank expressions which set them apart—while Lucinda looks normal. Being in a special class subjects her to some unkind remarks from the students in other classes. But within her class, Lucinda has special status because of her good looks. If she were more aggressive, she could be a social queen, but she is so passive that she does not make use of her chances. She likes school, though, because she is learning things like cooking and sewing, housekeeping, marketing, etc.

Her last psychological examination, taken 3 years ago when she was 11, resulted in her placement in the special class. The examination placed her IQ in the high 60's. Her "performance score was somewhat higher than her verbal." The psychologist did not find any symptoms suggesting that a neurological examination was necessary. There was no medical report.

Prior to entering the special class, she was in regular classes in a number of schools (the family moved often). Lucinda has to come across town to get to the special class, as it is the only one in the city suitable for her. When she first entered, she could hardly read. In 3 years, she has made a great deal of progress and is now reading at about the third grade level, although there are some third grade books, such as those on science and health, that she cannot understand. Her reading is of a strictly functional kind—simple directions, recipes, newspaper headlines, etc. She likes comic books.

The teacher is concerned about Lucinda's future schooling. She feels that the girl should be in a high school vocational education program that would prepare her for a job and help her to mature, but there is none in the city.

It was hard to get a history from Mrs. Parker, who was uncertain of dates, got mixed up as to what happened to which child and when, and recalled very little about each one's early development. In summary, nothing particular stood out in her mind about Lucinda's early childhood, except that she didn't stand up for herself as much as the other children.

At first, Mrs. Parker kept talking about Lucinda's "getting into trouble." But when I pressed for details, she would drift into talking about Mazie and

Dorothea and their boyfriends, and how she hoped they would get married before they got pregnant; so many of their friends had had illegitimate babies. Mrs. Parker was somewhat defensive about the fact that her youngest child was born long after Mr. Parker had left home 4 years ago.

It gradually became clear to me that Mrs. Parker's main reason for wanting Lucinda "put away" is that she thinks Lucinda can never get married, and won't be able to take care of a child. She seems to think Lucinda is in imminent danger of becoming pregnant. Mrs. Parker doesn't want to have to care for Lucinda's children. I tried to remind her that Lucinda isn't interested in boys yet, but it didn't seem to help. Her idea of Lucinda seems to be a mixture of her projections of her own sexual needs and concerns, a notion that "feebleminded" people are oversexed, and, in some complicated way, her own competition with Mazie and Dorothea. She kept talking about a girl in the neighborhood who was "feebleminded" and very promiscuous. She seems to think that Lucinda would be sterilized at the institution, and that this would be a good idea. But mainly she wants Lucinda out of the way of trouble—wants someone else to have the job of looking after her.

Lucinda started menstruating about 6 months ago. One of Mrs. Parker's complaints is that Lucinda is careless about disposing of her sanitary napkins. She tucks them away in dresser drawers or under the bed. Apparently, Mrs. Parker has not told Lucinda anything about "the facts of life," but assumes she has as much information as the older girls, although Mrs. Parker does not think Lucinda would understand much. According to Mrs. Parker, no adult had ever explained sex to her when she was a girl, and she expected her kids to "pick it up" the way she had.

Until Lucinda's menses started, Mrs. Parker had not thought much about having to do anything special about her. Although her main concern is fear that Lucinda will have a baby that Mrs. Parker will have to take care of, the teacher had raised the question of what Lucinda would do after she got out of school, and suggested that she be sterilized at the institution.

TEACHING POINTS

Popular Attitudes and Beliefs About Retarded Adolescents

Mrs. Parker is not unique in attributing to her retarded daughter a tendency for sexual "misbehavior." There is widespread belief that retardates are likely to be oversexed. Such a belief may be based partly on the publicity that is often given to an offense committed by a retarded person. A similar

crime committed by someone less easily labeled is not so likely to be of special interest to the general public.

Furthermore, the traditional programs for the retarded have tended in some ways to support such beliefs. First, large numbers were congregated within an institution, thus making them easily identifiable and increasing the statistical chances that a retarded person would commit an antisocial act, sexual or otherwise. Second, the frustrations of life in the institution of the custodial type—meager opportunities for satisfaction of many human needs, especially the need for social contacts with people of the opposite sex—probably increased the motivation to act out when on furlough or parole, or upon escaping. Under such circumstances, boys and girls could become involved in sexual misbehavior, either as a hostile gesture at society, or because of uncontrollable needs resulting from prolonged lack of normal satisfactions and outlets.

Parents who have been able to manage a young retarded child at home often become panicky as he approaches adolescence. The concern about retardation heightens anxieties—often of an unrealistic degree—that many parents feel about their normal adolescents. Thus, we find even those parents who can handle the problems of the normal adolescent with some degree of calmness sometimes becoming quite irrational about the retarded youth. For example, one mother insisted that her son be castrated so that he would not become sexually assaultive, although he was severely retarded (functioning at no more than the 3-year-old level) and, moreover, confined to a wheelchair. Even the idea of eventual adolescence can trigger such anxieties in some people, as in the case of the public health nurse who urgently recommended the immediate sterilization of a retarded girl who was only 8 years old.

Begab writes:

> "Adolescence is for many parents a source of panic. They wonder how much the (retarded) child should be told about sex, if anything, and often they tell him nothing—thereby sometimes contributing unwittingly to the problem. Neighbors complicate the matter by uneasiness about the youngster even when his overt behavior is above reproach. That these concerns stem from uninformed parental and social attitudes makes the problem no less real.
>
> "Sex education, hygiene and behavior are seldom part of the formal curriculum for retardates in schools and institutions. Yet many of these individuals will some day marry and have children or otherwise live socially independent lives. It is wholly unrealistic to expect them—especially those with mild retardation—to confine their activities to persons of the same sex or to understand proper codes of conduct with the opposite sex

without guidance. If given the chance, most can learn about menstruation and other bodily functions, about the development of secondary sex characteristics, social responsibilities, and acceptable dating behavior. The performance of these educational functions by the parents or by professional counselors can prevent other sources of family stress.

"The prospect of sexual misconduct among retardates is probably more pronounced in the disadvantaged family, particularly if the behavior of the parents is itself suspect. The retardate is not apt to incorporate society's codes when these conflict with the observed behavior patterns of his parents .... Even when parental behavior is acceptable the environmental stress to which the deprived retardate is exposed heightens his vulnerability.

"In an atmosphere of impoverishment and limited outlets for status and acceptance, sex can be readily equated with affection and recognition. This, too, can be corrected, but the solution does not lie in outmoded concepts of segregation and control. Treatment and guidance aimed at building up the retardate's self-esteem and inner controls is more likely to have constructive consequences. The risks *are* real but cannot be credited to low intelligence per se."[1]

Assessment of Behavior of Retarded Adolescents

In assessing the significance of sexual behavior for a child, retarded or not, one should view it, like any other behavior, in the framework of the child's developmental stage. For example, children normally go through stages when "modesty" must be imposed on them, when some genital stimulation is not unusual, when exploration with children of the same sex and of the opposite sex may occur, when oedipal fantasies develop or are displaced onto an other-than-parent figure, when the little girl "flirts" with men, and the little boy, with women. Children who are used to displaying affection to members of the family may go through a stage when they do not clearly understand the line between family and others to whom displays of affection are unwarranted. Such behavior occurring in a young child is usually a cause for teaching, not panic. There is generally a qualitative difference between such behavior and similar behavior on the part of a disturbed adult, and the child's age and size bespeak the innocence of his behavior.

[1] Begab, Michael J., "Mental Retardation and Family Stress." *The Institute on Mental Retardation.* St. Louis School of Social Service, University, St. Louis, Mo. June 22-26, 1966. pp. 22-23.

There is often a similar qualitative difference between the inappropriate sex-related behavior of the retarded youth and that of an adult, but the youth's age and size cloud his childlikeness. It is especially important, therefore, that the retarded adolescent's total development be taken into account in interpreting the significance of a sex-related act. Some severely retarded children are 15 or 16 before they begin to develop interests that 3- and 4-year-old normal children exhibit, and some never develop beyond this stage.

Recently developed training programs in various centers across the country are proving that much behavior once considered inevitable for certain degrees of retardation can be altered by training. For example, many institutions have considered the indiscriminate displays of or demands for affection on the part of institutionalized children on the wards for the moderately retarded (mental ages usually of about 2 to 5 years) as a function of their mental deficit. Some staff members believe this behavior results from the lack of individualized attention in the large congregate setting. Now it is recognized that nearly all such children can be taught socially acceptable behavior; that, to a large extent, it is a matter of training. In fact, it has been shown that many staff members were inadvertently encouraging inappropriate behavior by rewarding it. When few attendants had to look after large numbers of children, it was the aggressively affectionate youngsters who received most affection, reinforcing this behavior on their part and encouraging more timid ones to become aggressive.

In order to learn new forms of behavior, retarded children must have meaningful relationships with people who are significant to them, and the expectations of them must be commensurate with their capabilities so that they can experience success. One important reason for the sexual acting-out of many retarded adolescents is their feeling of isolation, worthlessness, and inadequacy. Often it is only through the sexual act that they can obtain even fleeting relief from the abysmal feeling of being a nonperson. Punishment, segregation, sterilization—the traditional ways of handling sexual offenses by retarded persons—have proven not only ineffective but often aggravate the problem.

Ignorance About Sex

When one considers the lack of privacy in the living situations of many of the culturally deprived, and the phenomenal activity of the "grapevine" in institutions, whether for the retarded or others, it is surprising that ignorance of the basic "facts of life" is an important factor in some sexual problems of the retarded. We take for granted that people who have grown up in large

families living in one or two rooms understand sex pretty well. Yet the very ways in which many of them learn contribute to their misunderstanding.

A child may frequently witness the act of intercourse but not connect it with the birth of a baby months later. It may be interpreted merely as an act of adults, to be performed when one wants to declare one's adulthood.

Furthermore, the veiled admonitions, nonspecific taboos, and other vague dicta passed on to children about most aspects of sex may result in peculiar interpretations. For example, one woman from a very poor family confided that "she had always thought that because she was married and in love with her husband, she could not become pregnant by anyone else. After her husband left her, experience had taught her otherwise, but she still did not understand the mechanics of procreation."[2]

As Begab has noted, the retarded, of whatever social class, are unlikely to be given adequate sex information either in school or by their parents. Thus, retarded culturally deprived adolescents cannot be expected to have an adequate knowledge base for proper sexual conduct, unless special efforts are made to overcome this gap in their education.

If to lack of teaching is added the lack of opportunity for normal progression of experience, from carefully supervised boy-girl relationships during early adolescence to the independence of married life, the retarded person cannot be expected to handle complicated heterosexual relationships without mishap. Generally, retarded adolescents are allowed fewer rather than more opportunities to learn step-by-step the complex set of behaviors needed for socially responsible boy-girl or man-woman relationships.

It is true that for the middle-class retarded child, it may be extremely difficult to find enough other children of the appropriate age, interests, social behavior, etc., to provide such graduated experiences in the neighborhood. It is usually necessary to look for them over a rather large area, which means an organization must sponsor a recreational program, and participation usually cannot be on the casual basis of most children's activities.

For culturally deprived, mildly retarded adolescents, suitable companionship should not be so problematic. They are usually not obviously different from many of their peers, and can participate in many of the same activities, especially if grouped with children a year or two younger. Of course, the primary problem is the lack of recreation facilities for all poor children, retarded or not. Whatever is made available to poor children is likely to help in meeting the needs of mildly retarded children.

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[2]Weinandy, Janet E., "Casework with Tenants in a Public Housing Project." *Journal of Marriage and the Family*, November 1964, p. 454.

But the difficulties are often not limited to such concrete problems. It sometimes happens that a parent attributes behavior to a retarded adolescent, or adolescent-to-be, which he is not actually exhibiting. A clinic for retarded adolescents reported that:

> "The most frequent requests for advice and counseling were related to the pubertal development and sexual behavior of the retarded adolescent. The developing sexuality of the retardate precipitated a near panic reaction in many family situations. *Yet in only about half of the families in which this was a major concern could complaints actually be substantiated.* [Italics added.] . . . In those cases in which sexual misbehavior could be verified, there generally was found to be much sexual stimulation present in the home situation, which promoted an exaggerated interest in sex and sexual acting out. Complaints regarding the male retardates most frequently involved exhibitionism, masturbation, or genital stimulation. With the girls, most complaints or fears were related to sexual promiscuity, pregnancy, and masturbation. As a group, these teenagers were extremely vulnerable and when actual problems existed they were generally due to poor environment, aberrant parental behavior, or exploitation by family members or associates."[3]

Lucinda is a good case in point. The record indicates that she is not only not misbehaving with boys but that she is not even interested in them. Apparently Mrs. Parker is ascribing to Lucinda the cause for concern about her two older daughters and, possibly, guilt about having a baby after her husband's desertion.

Here we see problems displaced onto the retarded child. As pointed out later in the case of Jimmy Johnson, a retarded child can become the victim of family pathology which has nothing to do intrinsically with his retardation. It may well be that the retarded child is more likely to become the family scapegoat than would be his normal siblings. The point is that the mere fact of retardation should not trap the worker into a careless or inaccurate diagnosis. The same kind of objective assessment of observations and reports should be made of a retarded child as of a normal or bright one. To paraphrase Begab, not everything "bad" can be "credited to low intelligence per se."

What else do we know about Lucinda, and what more do we need to find out?

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[3]Hammer, S. L., and Barnard, K. E., "The Mentally Retarded Adolescent." *Pediatrics*, November 1956, p. 850.

Need for Vocational Training and Vocational Opportunities

[illegible] not clear about Lucinda's vocational potentialities. Her interest in learning "useful" things is encouraging. Hopefully, by the time she has outgrown her present educational program, there will be a high school program available which emphasizes vocational education. If not, she may be eligible for help from the vocational rehabilitation agency which can provide appropriate job training, counseling, and placement.

In any case, we need to know more about her present level of functioning and indications for future development. Her rapid progress in the special class would suggest that she can continue to improve her academic abilities further, but a skillful examination is needed to corroborate or negate this. We also need to know in what particular areas her skills and interests lie. Not that the caseworker will take over the role of vocational counselor, but such information will help her in planning referral for vocational service and in carrying out her role as family caseworker.

As part of their service to families in which retardation is a factor, real or potential, family and child welfare service agencies can encourage and help other agencies to develop a full range of services for the retarded. One needed service, exemplified in this case, is a high school program for retarded children. Such a program would not only prepare Lucinda for the world of work through training in filling out applications, punching time clocks, getting along on the job, etc., but would also provide a normal milieu in which she could experience heterosexual relationships and have some opportunities for recreation.

It is also important that public and voluntary social agencies exert every effort toward the provision of recreational facilities for all children, including the retarded. Children more severely affected than Lucinda may require special groups for certain activities, and some may need specially devised programs that take into account their special handicaps. Many agencies have been unduly hesitant about opening their services to the retarded because they are unaware of the wide range of abilities and limitations subsumed under the term "retarded." Welfare agencies should encourage such agencies to consider including certain retarded children in their regular programs and initiating special programs for those who cannot fit into the regular activities.

Some Values and Limitations of Institutions for People Like Lucinda

We do not yet know what has caused Lucinda's retardation. Apparently her older and younger siblings are not considered retarded (although this will

need to be investigated further), so that if Lucinda's condition is due to environmental conditions one might wonder why she has been more strongly affected than the other children. Certain children are more vulnerable than others, partly due, perhaps, to environmental conditions during critical periods of early life. It is also possible that Lucinda has inherited a pattern of genes which predisposes her to retardation.

Whatever the reason for Lucinda's being different from her siblings—if it turns out that she is—their normality would suggest that the home has not been so severely deprived as some; that there has been more stimulation, less distraction, etc. It is important to know the climate of the home in order to determine what needs to be done to help Lucinda achieve her highest potential functioning level.

Mrs. Parker has asked that Lucinda be institutionalized, and the school has raised the question of further training which is not now available in the community. Lucinda's needs, assets, and limitations should be carefully assessed, preferably in a multidisciplinary clinic. Final plans will depend on the results. But, for now, let us look at what might be gained and what might be lost if Lucinda were to be placed in an institution.*

A primary limitation of the institutional setting is that it does not provide an accurate model of the society to which some of the retardates will eventually need to adjust. Many of the behavior patterns that are inculcated are incompatible with independent living. Actually, a very comfortable adjustment of a resident to the custodial aspects of an institution might and often does make his subsequent assimilation into the community very difficult.

Dilute, interpersonal relationships are the rule in institutions, tending to develop a kind of schizoid adjustment. Furthermore, institutional life tends to perpetuate and exaggerate immature role-sets in the residents. The individual must adopt a perpetual child-to-parent role in relation to the employees, and a sibling-to-sibling role in relation to other residents. Thus, depending on the kind and length of experiences prior to placement, the retardate who spends an appreciable part of his formative years in an institution tends to be much less prepared to successfully adopt family and community roles than the one of equal ability who grows up "outside."

Some of the factors presented above as difficulties for many retardates may be assets for others. For example, the impersonality of the institution may offer the emotionally damaged retarded child a rest from too intense

*The State institution described here may not be characteristic of some which have developed new programs and obtained more adequate support and staff. Furthermore, each institution has special strengths and weaknesses, and these would have to be considered in each case.

relationship demands and an opportunity to select from a number of possible relationships those which he can best tolerate at the time. With attendants, staff, and other residents, he may form relationships of a kind which he could not form at home because of the opposing needs of the other members of his family.

For the child whose former environment provided no stability, the routines of the institution may be, for a limited time, specifically therapeutic. The child whose personality is disorganized, who has not developed internal controls because of inconsistent demands at home, may benefit for a while from the rather clear, and usually rather inflexible, standards set forth for his guidance. Yet, just as a person who has had his fractured leg supported by a rigid cast finds his muscles weakened by disuse, so will the institutionalized individual who depends too long on outside controls fail to develop adequate self-control.

Group situations are more conducive to learning certain forms of behavior, such as accepting and carrying out rules, sharing, taking turns, standing in line, taking orders from a variety of people.

The child or youth with cultural retardation,* having experienced social, educational, and physical deprivation, may benefit in a special way from a limited period in an institution. He is usually not recognized as retarded until he has been in school for several years. By this time, he has probably suffered repeated losing battles in all kinds of competitions, except perhaps in the area of disruptive behavior. Consequently, he has often developed a picture of himself as inadequate, incompetent, and often "bad." For this individual, the institution can offer an opportunity to correct a destructive self-image.

There he sees many others much more limited than he is, and may find himself, for the first time, at the top of the status ladder. He is counted on for the most responsible jobs assigned to residents. His assets, rather than his limitations, are recognized. He begins to see that there are things he can do, and the resulting self-confidence is an important ingredient for future success.

Temporary freedom from the pressure of constantly losing out in the competitions in everyday life often does result in improvement in many areas of functioning which may be demonstrated by a rise of 20 or more points in IQ, as well as better functioning in school and at work.

The typical institution for the retarded provides other possible values, such as protection of the resident from the community and protection of the community from the resident. Variety and coordination of services, which

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*A shorthand term used throughout the cases to mean mental retardation causally related, in some as yet incompletely understood ways, to that condition called "cultural deprivation."

historically have not been available in most communities, have been important advantages of the institution.

To reiterate, the institution for the retarded, like the general hospital, may be the place which can provide the treatment of choice *for certain people at certain times.*

If Lucinda Parker is institutionalized, what benefits can we expect for her? If she were to continue her present pattern of behavior (interest in learning, acceptable behavior), she might be ready for a job and could return to the community by the time she is 18 or so (she would be 15 or 16 at the time of admission). We would not anticipate that she would be there long enough for overdependence on the institution to become a serious problem, although it could happen if she turned out to be a very dependent girl. When children are admitted before adolescence, the possibility of overdependence should be taken very seriously.

The particular institution would have to be assessed with regard to Lucinda's need to learn heterosexual relationships in a step-by-step manner, since all institutions do not make adequate provision for such learning.

There is no evidence so far that personal relationships are difficult for Lucinda. She has friends and no evidence exists of serious emotional damage among the family members. Consequently, we would not expect that she has a need for the impersonality of the institution. Nor have we reason yet to think she needs the external controls to compensate for a lack of internal ones.

If we find that the home is disorganized, with no routine, with insufficient attention paid to personal hygiene, etc., we might look to the institution to provide constructive experiences in these areas. The complaint that Mrs. Parker made about Lucinda's failure to properly dispose of her sanitary napkins, however, would lead us tentatively to expect something better, and the older children's better functioning would also suggest this.

It may well be that Lucinda might benefit from being among the "elite" of the institution, but we do not know that a feeling of being inferior is a serious problem with her. Her apparent success in the special class may have given her some feelings of success.

Thus, until we learn more about her and her family, we find no strong indications that institutional placement would have many values for her except as a place where vocational training can be obtained. If training can be obtained in the community, that would seem more advantageous since she would not have to make the drastic adjustment to the institution and then back to her home.

Mother-Daughter Relationship

The single-parent family headed by a woman is widely prevalent among the poor. In regard to the parent-child relationship in this type of family, Irelan has made the following observations:

> "A peer relationship often develops between the mother and her children of either sex. A son is sometimes expected to contribute economically and become the man of the house before he is really able . . . Sometimes, older daughters are seen as rivals, competing with the mother for the attention of male acquaintances. The prematurely adult role of a daughter is augmented when she has to become a housekeeper and part-time mother."[4]

We do not know enough about the Parker family yet to know whether Mrs. Parker is in a competitive relationship with the two older girls, but it seems possible. This, along with other factors, might also help to explain her overconcern with Lucinda's interest in boys.

Siblings of Retarded Children

We have very little information about the relationships among the family members. Dorothea may be a good influence on Lucinda because of her interest in school, and if relationships are good, she could be a strength in the family.

Siblings of the retarded are, in general, a forgotten group, so far as the literature is concerned. Recently, there has been some consideration given to what it means to a middle-class child to have a retarded brother or sister. As might be expected, reactions seem to depend on age, sex, parental attitudes, and other factors. Especially among adolescents, the feelings of the normal siblings may be quite strong because of their need to be accepted by their peers and because of their need to understand themselves, which includes knowing what kind of heredity they will pass on to their children. Among their concerns is one they share with their parents: "Why did it happen in *my* family?"

They also wonder why the sibling was affected rather than themselves, whether they will have to take care of him all their lives, and often about how to cope with the retarded child. In one case, the sister of a retarded girl was beginning to fail in school, withdraw from her social activities, and otherwise display depressive behavior. Her explanation was that she felt guilty because she was "all right" while her sister was badly afflicted.

Of course, normal siblings react in different ways to the fact of a sibling's retardation. According to one study,[5] 20 percent of the families reported

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[4] Besner, Arthur, "Economic Deprivation and Family Patterns," [in] *Low-Income Life Styles*, Lola M. Irelan, Ed.. U.S. Department of Health, Education, and Welfare, 1966, p. 22.

[5] Holt, K. S., "The Home Care of Severely Retarded Children." *Pediatrics*, Part 1, 1958, cited by Begab, *op. cit.*, p. 26.

emotional disturbances among the normal siblings of severely retarded children. Another author found that some siblings responded warmly and in a protective way to the handicapped brother or sister and also expressed interest in vocations in human services; others maintained a distance from or responded negatively to their retarded sibling, and expressed interest in vocations which are less person-centered, such as engineering, accounting, etc.[6] A third study found that brothers and sisters of the Mongoloid child tended to reflect their parents' attitude. Most of them took an affectionate, protective interest in the child.[7]

Schreiber and Feeley write:

> "Many parents of retarded children are panicked into the belief that their retarded child will adversely affect his normal brothers and sisters. However, in some families where the parents have dealt with the situation constructively, such young people have developed greater maturity, tolerance, patience, and responsibility than is common among children of their age. Our experience suggests that the young person with positive family relationships is often capable of enduring the emotional hurt and anxiety of having a retarded sibling without severe disruptions of his family and social life. He needs reassurance and support, but more often his primary requirements are educational. The more clearly normal siblings of the mentally retarded can see the realities of their particular situation, the better position they are in to cope with them."[8]

It seems likely that the culturally deprived, who suffer a higher incidence of physical defects and who generally have lower expectations for intellectual achievement, tend to take a more practical view of retardation than the middle class. A child who is so severely retarded as to require constant care and supervision may be seen as a cross too heavy to bear, because of the extremely difficult living circumstances and the number of other problems. On the other hand, the woman who gets most of her meager satisfactions in life from caring for a very young infant may find real reward from the retarded child's

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[6] Farber, B., and Jenne, W. C., *Family Organization and Parent-Child Communication: Parents and Siblings of a Retarded Child.* Lafayette, Indiana: Child Development Publications, 1963, Vol. 28, No. T.

[7] Kramm, Elizabeth R., *Families of Mongoloid Children.* U.S. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau, Children's Bureau Publication 401, 1963, p. 42.

[8] Schreiber, Meyer, and Feeley, Mary, "Siblings of the Retarded: A Guided Group Experience." *Children,* November-December 1965, p. 225.

prolonged dependency. The siblings, who are often quite isolated from each other, are likely not to be greatly concerned about each other, except as the older ones may be thrust into the role of caretaker of the retarded child.

It is important for us to find out how Dorothea, especially, feels about Lucinda, and vice versa. Not only can the older girl help Lucinda to learn many skills, but, if Dorothea turns out to be a rather stable, well-motivated girl, she could also be a good model for Lucinda.

It goes without saying that Mrs. Parker will need help in understanding Lucinda and in finding more constructive ways of handling the concerns which led her to become unduly alarmed about Lucinda. A large part of such counseling will probably center around giving information about Lucinda. Mrs. Parker should be encouraged to explain her beliefs about retardation which may have contributed to her (at least as yet) unnecessary anxiety about the girl. Even well-educated parents of retarded children are often exposed to false information. As a child welfare supervisor said, "Nowhere is the accumulation of misinformation, social ineptness, prejudice, old wives' tales, neighborhood gossip, and well-intended but ill-advised counsel more noticeable than around a retarded child in the home. Somehow communication must penetrate this accretion and convey new ideas and possibilities to parents."

And, as with the other cases, it is important that the other children in the Parker family be assessed so that necessary steps can be taken to ameliorate any retardation already present, or to prevent the development of this handicap.

JUNIOR MARTIN

(rebellious adolescent boy in foster care)

OBJECTIVES:
- To deepen understanding of some effects of institutional placement.
- To transfer an understanding of other children to understanding a "borderline" retarded child in regard to: separation; reaction to foster home placement; disturbed behavior.
- To deepen understanding of the need for individual diagnosis.

FOSTER CARE TRANSFER SUMMARY

Junior is 14 years old. He has been diagnosed as borderline retarded and does not get along in a regular classroom. His adjustment in the foster home has not been good. Alternate plans are now being considered for him.

Junior's own family lives in a rural community, in whatever shack they can find, usually rent-free. They stay until the neighbors complain too much about the noise, fighting, and dirt. Then they have to move again.

There are eight children. The oldest is in the penitentiary for armed robbery; the next child, a girl, has "no visible means of support"; the next boy is a school dropout, has no job, and has had a few minor encounters with the law. Junior is the next, followed by two girls, ages 12 and 11, both in the fourth grade; a boy, 8, in the third grade, and a girl, 6, who will start school in the fall.

Mr. Martin, age 41, works as a farm hand when he is not in jail for drunkenness or fighting. Mrs. Martin, age 43, is almost toothless, very obese,

and sloppy. The house is filthy, with junk and trash in the yard. Bedding is inadequate and dirty. The house reeks of soured and rotten food, dirty clothes, and human waste. There are not enough dishes; each person eats when he wants to, right from a common pot.

When he was 9, Junior was committed to the State institution for the retarded because he was misbehaving in school (fighting and cursing) and not doing any work. The school psychologist found him to have an IQ of 65 on the Stanford-Binet. Because the institution was already crowded, Junior was not admitted until 15 months later, after the agency had written numerous letters describing the dreadful circumstances of the home and pointing out that Junior would probably become seriously delinquent if he remained there much longer.

He stayed in the institution a little over 2 years, and then was returned home because he was "not mentally retarded." The institution did not send a complete psychological or medical report, merely informing the agency that his diagnosis had been changed to "without mental deficiency" and suggesting that he probably would do all right in a foster home, if a suitable one could be found for him.

Since no acceptable foster home was available, Junior was allowed to remain with his family. Attempts were made to work with them, and with Junior, but to an avail. After about a year, he stole a bicycle, and the court ordered him into foster care.

After only 3 weeks in the first foster home, he had to be moved because of his terrible language, bed-wetting, and temper tantrums. He was then placed in his present home, where he has been for a little over 3 months.

Mr. and Mrs. Smith, the foster parents, and their 19-year-old son, Dick, are very much interested in Junior. However, Mrs. Smith is not sure that she will be able to keep him because of his sullenness, refusal to join the family in activities, and, especially, his hostility toward Mr. Smith. Mr. Smith has tried to work with him, but Junior will not cooperate in any way.

It may be that a group home will have to be found for Junior, since he is not eligible to return to the institution for the retarded. Or, if he gets into any more trouble, he may have to go to the industrial school. The younger children may eventually have to be removed from the home, too.

Junior is sullen, but otherwise normal appearing. It is hard to talk with him because he only shrugs and says, "I don't know" or "I don't care" to almost anything you ask him. He has a big chip on his shoulder that is very easily knocked off. He claims there is nothing wrong with his treatment at home, that everything would be all right if he could just go back. He won't talk about the institution, except to say that school was better there. The only reason he gives is that they had woodworking and gardening which he liked, though he is bitterly sarcastic about the "dumb kids" they had there.

TEACHING POINTS

Many of the problems presented in this case are seen frequently in other foster care cases. They will be mentioned only briefly or discussed only as they are affected by the deprived family situation or by the boy's intellectual inadequacies.

Factors Relating to Cultural Deprivation

1. Junior's reaction to his foster father probably results from a number of influences, the significance of which we do not yet know. It is possible that he, like many other children in foster placement, is afraid that acceptance of the foster parents will jeopardize his relationship with his own parents. No matter how inadequate they may be, a child's own parents are tremendously important to him, as social workers well know.

Among the deprived, there is often a particularly strong, sentimental attachment of the boys to their mothers, regardless of the mother's behavior in general, or specifically toward the boys. It often has a defensive tone because the boy knows that his mother is not highly regarded by the community, and perhaps because he, himself, feels she does not measure up. But he feels bound to champion her against all comers. It may well be that the absence of the father from so many of these homes heightens the oedipal relationship.

Junior's idea of what a father is and does is probably not conducive to his accepting Mr. Smith's attempts at building a relationship. In homes like his, if the father is present, he is often seen as ineffectual, useful only in relation to his earning capacity, and punitive. The fathers are often abusive to their sons, especially as the latter approach adulthood.

It may take a long time for Junior to learn a different concept of the adult male, but it is important that he do so. This will help break the generation-to-generation cycle and make it possible for Junior to develop into a self-respecting adult. It may require special effort on the part of the caseworker to reassure Junior that a good relationship with Mr. Smith will not adversely affect his chances of going home.

Also it will probably require considerable interpretation to the Smiths to help them tolerate Junior until his fears have been allayed.

2. We do not know what the relationship is between Junior and his brothers. Often, families who feel alienated from and endangered by society show a solid front when one member is in trouble, but carry on more or less bitter warfare among themselves when not under pressure from the outside.

Consequently, a direct question to Junior about his brothers will probably bring either a non-committal answer or a bland avowal that the relationship is good. One might look to the relationship between Junior and the Smith boy for some clues.

This relationship is important not just for a better understanding of the Martin family and of Junior, but also because it holds strong potential for reeducating Junior. A relationship with a foster brother may not be as threatening as a relationship with a foster father, so that Junior might more readily accept the Smith boy as a role model, especially if there are mutual interests. Considering the reports on Junior's brothers, the presence of an older boy who can demonstrate to Junior a socially acceptable role for a young male would be a valuable treatment asset, provided, of course, Junior will accept the relationship.

3. One wonders about Junior's ability to take on quickly the customs and manners of the Smith family. Certainly his life at home has not prepared him to sit at a table and eat with other people in an acceptable manner. Even his institutional experience may not have helped much. Proper table manners, polite conversation, etc., have not always been the prime concern of institutions for the retarded. We do not know what Junior's particular experiences and training have been, but the worker should be alert to the possibility that Junior might feel particularly inept in matters of social behavior. It would be well to check with Mrs. Smith about his behavior at the table—whether he can relax and enjoy the meal, or if he only picks at his food, or manages to miss meals whenever possible.

There are probably other aspects of life in the Smith home which are embarrassing to Junior because of his lack of training. Mrs. Smith may need to provide special opportunities for him to learn acceptable behavior in private, in order to help him to become more comfortable in the family.

Factors Relating to Mental Subnormality

The term *subnormality* is used in this caption instead of *retardation* because Junior has been diagnosed as being "without mental retardation," but he is still not able to perform adequately in school. We do not know specific test results which led to this diagnosis, but we can surmise that the scores were significantly higher than the preadmission test scores. As noted before, it is not unusual for children to show substantial gains in intellectual functioning after a period of institutional placement. Probably, a number of factors combine to cause this IQ rise, including some of the following.

1. Circumstances of testing. Quite often, the first test is given a child because he has gotten into trouble and a plan needs to be made. Under such

circumstances, there is often an air of emergency, a sense of drastic results of misdeeds, suffusing his life. Furthermore, the child is usually unfamiliar with the place in which the test is given, and often has been driven many miles from home—or wherever he is staying—to the clinic or office. Under such circumstances of strain and anxiety, it would not be surprising if the child performed much below his maximum or everyday level.

A good example of the paralyzing effects of testing circumstances is offered by the behavior of a young boy, about 9 years old, who was asked by a psychiatrist what his father did. The child shrugged, possibly because he did not know or care, and possibly because he did not trust the stranger well enough to hazard a reply. The psychiatrist then told the boy his father was a miner. Later in the interview, the question was repeated, evoking the same non-committal answer. The psychiatrist interpreted this "inability to learn" as signifying the child's low level of intelligence (below the educable range). Longer acquaintance with the boy proved him to be only mildly retarded, to be well aware of his father's occupation, but also to be extremely distrustful of strangers. Not knowing what use the doctor would make of the information, distrusting authority generally, and having heard wild tales of what psychiatrists did, he pretended ignorance.

2. Admission to an institution is a traumatic event under the best of circumstances. Children tested immediately after admission cannot be expected to demonstrate their maximum abilities. Results of tests administered after the child has made the transition are usually much better indicators of his ability. Consequently, it is important, in evaluating the change in performance levels, to know when the various tests were given and under what circumstances.

3. Reactions to separation. Social workers are well acquainted with the deep hurt most children suffer when they are separated from their families, even when the family relationships have been far from happy. Much depends on how they are prepared and what help they get after separation.

Many people fail to recognize the retarded child's need for help with separation, a need which he shares with other children. The retarded child may, because of his intellectual handicap, need more help than other children to understand the reasons for the separation and the benefits that would come from it. Unfortunately, thousands of retarded people have been placed in institutions with little or no preparation, or with misdirected attempts to "sell" the institution by making impossible promises.* Other common obstacles to adjustment are the dreadfully distorted and frightening images many people have of institutions.

To prepare a child adequately for a new experience, workers must be reasonably well acquainted with the major aspects of that experience. Several

factors tend to make it difficult for workers to become sufficiently well versed about institutions: the geographic isolation of many State institutions; their traditional social separation from the surrounding community; their complexity; and, perhaps, an unconscious avoidance of the subject because of the very fact that institutions house hundreds of very deviant people.

To overcome these barriers, many institutions have set up programs to acquaint agency personnel with their programs, policies, and atmosphere. The agency need not wait for the institution to take the initiative, however; it should seek opportunities for workers to become familiar, in some detail, with various aspects of the experiences their clients will undergo. For example, when a worker needs to visit the institution as part of his work with an individual client, he might make arrangements ahead of time to talk with someone about the broader picture as well, and, if at all possible, observe a number of the programs. Many institutions are not as skilled as welfare agencies in dealing with separation problems of children, and most would welcome the cooperation of welfare staff in developing more effective ways of preparing children (and adults) for admission, and for helping them adjust after admission.

4. Effect of Junior's "not being mentally retarded." One beneficial effect of institutionalization on mildly retarded, culturally deprived children which may account in part for the initial rise in IQ is the change in their status in relation to others around them. The resulting improvement in self-image has been described (p. 34-35).

We can, thus, expect Junior to have mixed feelings about being removed from the institution and returning to his former status as "low man on the totem pole."

A real problem is faced by many people who do not technically qualify for programs for the retarded, but who find it difficult to function adequately in programs for the normal. Hopefully, programs can be found for Junior which will take into account his need for special methods in certain areas, but which will allow him to function with his peers in those areas in which he functions normally. Since welfare agencies work closely with so many children like Junior, it is imperative that they take an active role in working with other agencies for programs for such children.

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*One girl brought a supply of nurses' uniforms with her to the institution because she had been told she would be trained as a nurse; a Mongoloid boy had been promised by his anxious mother that the institution had a swimming pool, which it did not; one newly admitted woman expected to be given a private room because of what she had been told.

Importance of Work with the Family

Welfare workers are fully aware of the continuing importance to a child of his own family when he is in foster care. But it is also important for the agency to work intensively with his family for another reason—to try to ameliorate the destructive effects of the home conditions on the other children still at home in order to reduce the degree, or prevent the development, of mental retardation in them. If preventive work is not initiated at once with the Martin family, it is quite likely that several or all of the four younger children will later require services for severe problems.

JOANNA REDFIELDS

(case of dependency resulting from long-term institutional living, value of homemaker service)

OBJECTIVES:
- To deepen understanding of some effects of institutional experience.
- To understand need for education and reeducation of some retarded adults.
- To understand homemaker's role in educating deprived parents.

CASEWORKER'S SUMMARY

Joanna Redfields is being referred to the Homemaker Service for help in managing her children and household. She is 29 years old, the mother of three children. Her husband died in a car wreck about 2 years ago. Up to that time, the family had managed at a minimum level because Mr. Redfields was a good manager. He bought everything for the family—groceries, clothes, school supplies. Joanna wasn't much of a cook, but she could boil or fry the simple things her husband brought home. Since his death, she has been almost helpless. Conditions have gone from bad to worse, and the neighbors finally complained to us about the foul condition of the house and children.

Joanna's main trouble is that she had never known any real home life until her marriage 7 years ago. She had lived in an isolated rural area with her poverty-stricken family until she was 10 years of age. She and her brothers and sisters went to school just often enough to keep the attendance officer away. Organized family life was nonexistent: the children and adults ate whatever

was handy, whenever they wanted it; there were no sheets on the beds and not enough beds to go around; clothes were worn until they fell apart and then discarded in a pile.

Joanna says that at age 10, she was "found" by the "welfare woman" and committed to the State institution for the retarded, where she stayed until she was discharged at 22. At the time of discharge, she had already been working in various private homes for 3 or 4 years, under the supervision of a social worker from the institution. She had never gotten into any trouble, was able to do housework quite satisfactorily, and wanted to marry Rupert, so the institution granted her the discharge.

After his sudden death, she was so demoralized that she was unable to tend to anything, except to see that there was something for the children to eat—it didn't matter what, so long as they weren't crying. By the time she began trying to pull herself together, things were in such a bad state that she never has been able to get control of the situation. There was absolutely no money coming in until the welfare checks started arriving. She had to move because she could not pay the rent, and the effort in cleaning her present house was so discouraging that she has given up trying. The only kind of meat she knows how to cook is hamburger—and that, only one way. The children quarrel about always having the same thing to eat, and she is tired of it herself but afraid to buy anything else because she doesn't know how to fix it. She buys canned beans and bread. Even so, her money runs out before the month is up. The children have been begging from neighbors; she says she hates it but can't blame them for doing it and doesn't know how to stop them. She doesn't want to face her neighbors, so she goes out of the apartment less and less. She usually sends the oldest child to the store so she won't have to go herself.

As I worked with her, I got the picture of a person who was very dependent but not nearly as retarded as she seemed at first. Her trouble was less that she couldn't learn than that she felt she couldn't. Her home life as a child had not prepared her to carry any responsibility. She had done pretty much as she had liked. She had not been mistreated, but neither had her dependency needs been satisfied; nor were they satisfied in the institution, where she was mostly an untroublesome, docile worker who did what she was told—no more and usually no less. But she developed a feeling of being unable to do anything on her own. She remembered that when she was younger, she had tried a couple of times to be especially helpful by doing some extra chores. Instead of being praised for her good intentions, she had been scolded—she still didn't know what she had done wrong, but she had decided not to do anything she hadn't been told to do.

Joanna is not able to verbalize many of her feelings about the institution nor about what that experience did to her. She learned many useful things, and at first she was grateful for being able to count on three square meals a day, a

clean bed, and clean clothes. She enjoyed many of the activities, such as dances and going to town occasionally for special events.

But as she talks, I get a sense of her developing a deep feeling of worthlessness and inability to make decisions. She seems to sum up these feelings of inadequacy in the term "retarded," which she uses frequently in talking about herself and always in a very derogatory way. Sometimes I get the feeling that she is subtly expressing hostility to the world for putting her in the institution. She expresses this partly by playing on her "retarded" condition, which she uses to excuse her failures in a lot of ways. For example, when I first went to see her, and had to explain that people had become concerned about her way of life and her failure to take proper care of her children, she said, in a sneering way, "What can they expect? I'm retarded!"

After we got past this stage, however, and she began to let me help her work out ways of managing better, I discovered that she can learn and that she wants to learn. But I have to take things slowly with her, and go over each step again and again. She needs a lot of praise when she does things right.

The first thing she asked me to do was to teach her how to fix hamburger some other way. I suggested meat loaf. At first, she insisted that that was too complicated, that she couldn't learn—"because she was retarded." But I told her what to do, step by step; we even went to the store and bought the ingredients. I wrote down each thing she did, as she did it. She was thrilled at the result, and the kids loved it. But she still had to disparage herself, saying I had done it, not she. So I encouraged her to try it again later, and that time I stayed out of the kitchen, letting her do it herself, with only my encouragement and occasional reminding of what she had done the last time. She was really elated to find she could do it. Now she wants to learn how to cook vegetables and, perhaps, some other inexpensive meats. I told her I wasn't too good at that sort of thing, but that I would arrange for a homemaker to come periodically and teach her not only to cook, but how to clean house, manage the children, etc. At first, she took this as another rejection, and was very hostile and withdrawn for several weeks; but, when I convinced her that I would still work with her on different matters, she finally relented.

The homemaker will have to be very patient and understanding. If she goes in and tries to clean up the house from top to bottom—which it certainly needs—she'll lose Joanna's cooperation immediately. But if she lets Joanna take the lead in suggesting activities, they will eventually get around to housecleaning. Joanna needs direction not so much in how to do each cleaning job—she learned that well in the institution—but in what order to do each, and how to fit them all into other tasks and responsibilities, such as preparing meals, tending to the children, etc. In other words, scheduling and deciding among conflicting demands are her areas of weakness.

One reason for asking for the homemaker is that telling Joanna what to do, especially about a complex matter, does little good. She needs to be shown everything, and this the homemaker can do. The main purpose is teaching, so the homemaker should be someone who can break down each task into steps. Joanna will also need a great deal of emotional support while she is learning. She needs to have her strengths pointed up to her, since she stresses only her weaknesses. She needs to learn that failure—whether of mild or severe degree—is not always final; that she can try again, instead of giving up because she's "too retarded to learn." While the homemaker is working with her, I will work on this aspect of her problem, too.

It would be good if the homemaker could eventually suggest that Joanna invite some neighbors in for a simple party. It is very important to break up her withdrawal tendencies, which have been getting worse since her husband's death. The homemaker should pursue any other opportunity that develops to get Joanna out of the apartment. It is astonishing how little Joanna knows about the city and how to get around in it. She is terrified of riding the bus and will use the telephone only in a real emergency. While her husband's dependability and capability were a boom to her and the children, he really continued the pattern of overprotection begun by the institution, so that she has never had any reason to learn that she can master the unknown. I expect the homemaker will need to go to the home every day for several weeks until she has obtained Joanna's cooperation and they have made substantial inroads on the disorder and dirt in the home. After that, this case could go on the "occasional" list, so that any time this homemaker is not needed for another job, she could help Joanna. When she is ready to start this "occasional" work, she should be sure that Joanna sees it as a sign of her own progress and ability and not as a rejection. I'll also try to help interpret the plan to her.

TEACHING POINTS

For some agencies, this may be an unusual way of using a homemaker service; yet it is sound in relation to the treatment goals for the family, and administratively sound, too. Homemaker service supervisors may be faced with gaps between cases. Such gaps often pose the dilemma to the administrator of paying the homemaker for the time she does not work, or employing her on a part-time basis and taking the chance of losing her to a full-time, salaried job. Scheduling service to families where retardation is a problem can fill these gaps. In the case of a mother who has the constant care of a physically handicapped retarded child, the homemaker can provide occasional relief so that the mother can tend to other responsibilities or merely get some rest and recreation. In

Joanna's case, the purpose is to teach and demonstrate better housekeeping and child care procedures to a retarded client. In either case, the cost of the homemaker service is far less than the probable alternatives—family breakdown and/or placement of one or more children in foster care.

If Joanna's children are not to perpetuate the pattern she has followed, it is vital that they experience the kind of home life which society would like for them to provide their children in the future. Every effort should be exerted to make this possible within their own home, and only after all attempts have met with failure should foster care be considered.

Dependency Problems Exaggerated by Institutional Experiences

In relation to the case of Junior Martin, the problem of the exalted status of the nonorganically damaged, mildly retarded institutional resident was discussed. In the case of Joanna, her personality apparently did not cause her to assume this status. Rather, her problem was one of dependency, which was aggravated, rather than alleviated, by her institutional experience.

> "Along with group living in a setting specifically designed to care for irresponsible people goes the serious problem of dependency. Initiative and responsibility cannot flourish when regulations and routines which were devised to protect and manage the least capable patients must also be followed by the most capable ones. Nor is a habit of industry fostered by an environment in which hundreds of people sit idle, whether the reason for their inactivity is their own handicaps or a lack of available occupation."[1]

Many institutions now have programs and policies which encourage the development of independence and initiative, but most institutions of a few years ago tended to foster dependent behavior and feelings of inadequacy in their residents. Apparently this kind of attitude characterized the institution which molded much of Joanna's behavior.

While such behavior is not adaptive to the community and, in this case, constitutes the primary problem to be worked with, it should be recognized that, in developing such a pattern of behavior, Joanna was adapting to her environment. In other words, she had reacted constructively to her environ-

[1] Nagler, Benedict and Kirkland, Marjorie H., "Institutional Preparation of a Retarded Patient for Vocational Rehabilitation." *Mental Health in Virginia*, Summer 1960, p. 19.

ment. Although she is less malleable now than she was in her pre- and early teens, the ability to adapt to circumstances is probably present still. But she will need to learn a whole new set of behaviors, acquire different feelings about herself and other people, and gain an understanding of what is expected of her. These expectations must be spelled out for her slowly, simply, and repeatedly—in much the same way that most children learn, as they grow up, what is expected of adults. In other words, Joanna needs reeducation. She needs to be taught independence, just as she was taught dependence. Some of this reteaching can be done by the caseworker, but much needs to be demonstrated on a day-to-day basis and is more appropriate to the homemaker's role.

ROY PETERS

(adult in need of vocational training)

OBJECTIVES:
- To recognize strengths in a person which can facilitate his rehabilitation.
- To become acquainted with expanding job opportunities for the retarded.
- To understand some effects on children of the father's success or failure in carrying out his role in the family and community.
- To deepen understanding of self-concept and its effect on behavior.

CASEWORKER'S SUMMARY

(for referral to vocational rehabilitation counselor)

Roy Peters, now 39 years old, is mentally retarded, has never worked outside his home, and has never been to school, but his wife, Emma, 35, is urging him to be trained for some kind of job. Roy does not seem to object, but the motivation seems to come principally from Mrs. Peters. They have two children, a 5-year-old boy and a 3-year-old girl.

Roy is polite and reliable, and, in spite of a rather silly laugh and blank expression, he is liked by those who have known him for some time. Roy was an only child, born to parents who were middle-aged before they were married. He was sent home from school his first day with a note from the teacher who said he would never be able to do school work. So his mother kept him home.

She taught him a little reading and arithmetic, and he learned to do nearly all the chores around the house. He also worked with his father on the farm and could plow with a mule quite well. But when his father bought a tractor, Roy was not allowed to run it for fear he would have an accident. His main chore was looking after the chickens. He was very good with all animals.

When Roy was 24, his father died. His mother began to sell off the farmland piece by piece to have money to live on. She began to worry more and more about who would look after Roy when she died. For this reason, though she had always tried to keep Roy from becoming interested in girls, she finally agreed to his marrying Emma when he was 30, by which time Mrs. Peters was 72.

Emma dropped out of high school in the 11th grade to go to work to help support her brothers and sisters. For 10 years, she worked as a babysitter, maid, and waitress until the younger children grew up. Then she married Roy, knowing that he wasn't very bright but liking him anyway, and thinking she would be able to help him. She thought his mother had babied him too much, and she tried to help him grow up. She and Roy's mother had gotten along quite well except when Emma would keep after Roy to go out and find a job. Then his mother really became angry, claiming that Emma just didn't realize Roy was retarded. Finally Emma had given in and "quit bugging" Roy, even after the children came. Instead, she went to work part time, leaving Roy and his mother to take care of the children, which they did very well.

Then, 6 months ago, Roy's mother died. Emma felt more and more strongly that it was important for Roy to go to work, not only because of the money but also because of the effect it would have on him and on their son, Tim. The boy had asked several times why his Daddy didn't work, and once had come home crying because some kids in the neighborhood had teased him about having a "dummy" for a father.

So Emma came to this office to find out if she could get some help in taking care of the children if she went to work full-time and Roy took some training.

I have my doubts about Roy's being able to get a job. I tried to talk Emma into letting Roy take care of the children while she worked full time. But she insists that Roy can work, that he works well around the house, especially if he has someone to supervise him and tell him what to do next, and I agree it would be better not to reverse roles if it is not necessary.

According to Emma, Roy takes good care of tools and equipment. When he was helping his father on the farm, he looked after the harness room and kept the milk shed clean; he looked after the chickens without being reminded.

The family home with its three-acre plot of land was left to Roy when his mother died. The Peters have a garden and keep a few chickens. Although job opportunities in this rural area are few, they hope they won't have to

move, as they doubt they could make enough money to buy such a good house and lot elsewhere.

As soon as you decide whether Roy can be trained for a job, please let us know, so we can plan for the children. We have made arrangements for Emma to leave the children with Mrs. Roberts, a neighbor, when Roy has to go for interviews and tests. If he is accepted for training, we will pay for the children's care until he gets a job, so we would like to know approximately how long the training will last, and when it will start.

TEACHING POINTS

Suitability for Training

Only recently have we begun to learn how many jobs the mildly retarded can do when properly trained. Training programs and job opportunities used to be limited to a few service functions, such as busboy, simple janitorial work, etc. In the last 5 to 10 years, as greater emphasis has been placed on vocational training and job placement for the retarded, the number of possible kinds of jobs has multiplied many times. In some instances, simple tasks which had been part of a more complicated job are now being assigned to a handicapped person; in others, tasks have been engineered so they can be done by retarded persons. In many instances, though, the placement of a retarded person in an unusual (for the retarded) job has resulted in an assessment of the client's particular strengths and weaknesses in relation to the demands of a variety of jobs.

In other words, if one approaches a client with a preconceived list of jobs that he might hold and tries to fit him into one of those slots, chances of failure are fairly good. If, however, one looks at what the client can do, looks for tasks or jobs that require those skills, and then checks to be sure his weaknesses do not materially interfere, a number of promising possibilities are likely to turn up.

The purpose here is to broaden the worker's appreciation of the range of possibilities. It is quite possible that Roy could become a veterinarian's helper, performing many useful functions and relieving the professional person of many time-consuming chores. Depending on the job opportunities in the community, Roy might work in a hatchery or he may be able to learn to use farm machinery and help on nearby farms. His parents were afraid to let him try working with machinery, but he should have a chance to show whether he can or not.

It is also possible that Roy's love of and skill in caring for animals can be translated into caring for people. The record does not specifically say so, but one might infer that Roy's management of his children is at least satisfactory. He might respond quite well to caring for people in a nursing home, or become an orderly in a hospital.

There are many things he might be able to do, but much more must known about him. He needs to be evaluated for vocational purposes.

Strengths and Weaknesses

In this case, the client has a number of strengths already documented. His social acceptability is an important factor; his ability to carry out responsibilities assigned to him (caring for the chickens, cleaning out the milk shed, etc.) augurs well for his job performance when trained; his skill in caring for animals may suggest several job possibilities.

A possible weakness lies in Roy's years of carrying out the "I can't do much" role. We do not know how intellectually limited Roy is, but what we do know suggests that he might well have functioned at a somewhat higher level had his parents allowed him to do so. Not only will it be necessary to give Roy a chance to reach past his present level under supportive conditions, he also needs a chance to learn to think of himself as a person who can do more than he has so far achieved.

Self-Concept

As has been noted before, the retarded—and many of the poor—often seem to be oriented to avoid failure. And people who have habitually failed tend to protect themselves from their own feelings about, and reactions of others to, their failure by not taking chances. If Roy's lack of enthusiasm about going into training is due to his fear of investing himself in something that may cause him to fail, counseling may be needed to encourage him to make a meaningful effort. And he will undoubtedly need continued support, once he ventures into the evaluation-training situation. It is likely that Emma's rather obvious strengths can be greatly supportive to him.

Family Roles and Relationships

The worker's recognition that the whole family would profit if Roy could assume the breadwinner's role is sound, as is her realization that, if this is impossible, he would still have a valid and useful role as housekeeper. Her

apparent pessimism about his chances of earning a living is hardly warranted at this stage. Unless some drastic weaknesses are uncovered, Roy sounds like a good prospect for vocational training.

Emma is quite correct in feeling that it is important to Tim to have as a model a father who acts the role of head of household. If Roy cannot do this, special efforts will need t be made to provide Tim with an understanding of that role. Otherwise, he may tend to perpetuate the distorted family relationships. In addition, Emma would need help in changing her expectations of Roy.

THE JOHNSON FAMILY

(family with several mildly retarded children)

OBJECTIVES:
- To recognize signs of "cultural retardation."
- To understand individual differences in intellectual and personality development as partly responsive to environmental influences.
- To recognize some emotional factors often present in the behavior of retarded children.
- To appreciate the need for complete evaluation of each child.

INTAKE SUMMARY

The Johnson family applied for AFDC after the father, Sam, was sent to the penitentiary for committing incest with his daughter, Nancy, age 16. After giving birth to a baby, Nancy was sent to the State institution for the retarded where she is now. Her baby was placed in foster care, as adoption was not feasible because of his genetic background.

Mrs. Johnson, age 31, moved to the city from a rural courthouse town in a depressed area of the State because of the publicity and community hostility engendered by the information brought out in court. At present, the family consists of the mother and five remaining children. Mrs. Johnson cannot work because of the two preschool children.

Mrs. Johnson shows evidence of strain, fatigue, and worry. Her feelings of hopelessness, inadequacy, and anger at the world in general lie not far below the neat, clean, and pleasant but guarded exterior. She tries "to bring the children up right," but feels her husband failed her in most ways. For a while,

he worked hard and made good money, but he gave up a good job in a distant city to come home because he was sure she was "playing around" with other men, a charge she firmly denies. He had always been jealous and suspicious, and whenever he got mad, he claimed that Jimmy, the 9-year-old, was not his.

At one point, Mrs. Johnson moved the family to the city where Mr. Johnson was living and working in the hope that this would calm him down. For a while it did, but Mrs. Johnson hated living away from her own family, didn't know anybody, didn't know where to shop, etc. She and Sam began to quarrel, and he started his old complaint, so she decided to move back to live with her own family.

This made Mr. Johnson very angry, and a short while later he quit his job and came home "to keep an eye on her." Then Mrs. Johnson found out he was "messing around" with Nancy. She was so outraged, especially since he was always accusing her of misconduct, that she promptly turned him in to the police. She still thinks that was the right thing to do, but if she had known how the community was going to react, and about all the newspaper publicity, she might not have done it. She might just have run Sam away from the house.

The Children

NANCY: When I asked Mrs. Johnson about Nancy's reaction to her father, Mrs. Johnson expressed considerable confusion and anger. In spite of everything that had happened, Nancy sometimes throws it up to her mother that she—the mother—caused her father to be put in prison; at other times, Nancy is certain she will never write to him or see him again. Mrs. Johnson can't understand Nancy. The school and the clinic told her Nancy was mentally retarded, but Mrs. Johnson is not clear about what mental retardation is. She keeps saying there has never been any "crazy person" in her family.

Mrs. Johnson has mixed feelings about Nancy's being sent to the institution. She obviously thinks of it as punishment, and sometimes feels Nancy should be punished for what she did; at other times, she feels Nancy was a victim—like herself—of Mr. Johnson's selfishness, strength, and possible violence. The court has told her Nancy would get some training there that would help her to get a job. Mrs. Johnson thinks that would be just fine, but why did Nancy have to go so far to get training? Besides, she doubts that Nancy would learn. The girl had skipped school when she was at home and wouldn't go regularly, even before she got pregnant.

JANE: I find it hard to get a picture of what 13-year-old Jane is like from Mrs. Johnson's description. She obviously is the one who takes orders well—at

least in such things as staying home from school to watch the two youngest children when Mrs. Johnson has to go shopping. But Jane often leaves small tasks undone, or half done, or does them wrong. She is amenable and quiet, and Mrs. Johnson depends on her a lot.

Jane's previous teacher told Mrs. Johnson that Jane is mentally retarded. Mrs. Johnson counters this by saying Jane certainly isn't crazy. "The child has failed grades," she says, but that was mostly due to her having to stay home to take care of the little kids. She won't listen to you sometimes, so that she does the same dumb things a lot of times, but that is just stubbornness. Jane doesn't talk back to you, or act sassy like Nancy."

The report we received from Jane's previous school said she was "educable" and should be in a special class, but there was none in that small town. Her IQ on the test given to everyone in the class was 61. At age 13, she was placed in the fifth grade but was able to do only second grade work, except in arithmetic. She knew her multiplication tables and, if asked questions about money, could add and subtract quite well. She was quiet, withdrawn, and seemed lonely. She never participated voluntarily in anything. Since the teacher had a large class and couldn't spend much time on Jane, and since Jane could not keep up with much of what the class did, she sat for hours, a book open in front of her, apparently doing little but dreaming. She missed an average of 6 days a month, but the school did not take action. (Jane has not been in school since moving to the city.)

JAMES: Jimmy, age 9, is in the second grade. I couldn't get from Mrs. Johnson a real picture of what Jimmy is like until it became clear that she was afraid he might be taken from her. Her fear was caused partly by what happened to Nancy; but even before that, by the experiences of some of her neighbors and relatives. Only when this anxiety was allayed was she able to tell me about Jimmy.

The report from Jimmy's previous school to the agency stated that he was absent a great deal because of colds, earaches, and inflamed tonsils. He often came to school sick, and the teacher would have to send him home. The school had urged Mrs. Johnson to take him to the doctor, but she had not done so.

The report stated that he was immature and given to crying and whining. Once in a while, he would lash out at anyone who made him mad. He sometimes threw rocks at the other boys, and then he was likely to get beaten up. He often took other children's pencils, books, toys, and sometimes money. Because of his small size and poor achievement, he had been kept in the second grade; but he would probably have been placed in the third grade next year had he stayed in the town, although he can hardly read or spell. He can do simple

counting and add and subtract small numbers when the problem is put into concrete terms. His speech is slurred, and his vocabulary small.

Mrs. Johnson alternately accuses Jimmy of being "just like his pa" (when he has done something wrong) and of "not being like his pa is" (when he is sick or acting babyish). His father prided himself on his size, strength, and manliness. That was why he claimed Jimmy wasn't his--he couldn't admit that a puny child was kin to him. Mr. Johnson was always making fun of Jimmy, and when Jimmy would come home crying because somebody had done something to him, he would tell Jimmy to go out and fight--to stand up for himself. Mrs. Johnson doesn't know what she's going to do about Jimmy: the neighbors are complaining about his hanging around their houses, and once a storekeeper had refused to let him come into the store because, he said, Jimmy stole things.

ROSEANN: At age 6, Roseann is a cute, freckle-faced girl with tousled hair. According to the school, she is a prize performer in the first grade because of her clear, sweet, and surprisingly strong voice. She is more outgoing than the other children in the family and participates actively in class. But she also has some speech problems, particularly some baby talk and poor articulation. She is behind in reading readiness, partly because she is restless and won't sit long enough to do her assignments.

WAYNE: At age 4, Wayne presents no special problems to his mother. She wonders about some peculiar behavior she notices occasionally. Every now and then, when he is talking or doing something, he will suddenly stop and look sort of blank, and then sometimes when he "comes to," he will have lost track of what he was doing or saying. This hasn't bothered her too much except once when he was going downstairs he missed a step and tumbled the rest of the way down, bruising himself pretty badly. She has not taken him to a doctor, and isn't sure a doctor could do anything or that there is any reason for him to do anything. She figures Wayne may outgrow it, especially since "it just happens once in a while." He watches TV most of the time and knows all the programs and performers, which is a source of pride to Mrs. Johnson.

SUSIE: According to Mrs. Johnson, Susie, age 2½, is "fine," but, when I asked about the child's vocabulary, she said Susie doesn't use many words. She makes noises and uses gestures to get what she wants, but Mrs. Johnson hasn't noticed much difference from the other children at the same age. She is toilet-trained during the day; the only problem is that she won't go without her bottle. Several times, Mrs. Johnson has tried to take it away, but Susie has yelled so

that the other kids gave it to her. It is easier just to let her have it. Mrs. Johnson doesn't remember when Susie began sitting up, walking, etc.—at about the same ages as the other children, she thinks.

I had difficulty pinning Mrs. Johnson down on any dates. The fact sheet information was obtained only with the help of reports from school, a birth certificate for Wayne, and much going over of ages, etc. I am trying to verify the dubious dates.

TEACHING POINTS

The teaching points to be derived from the above information are intended to aid in the understanding of cultural retardation and the needs of families who are, or are likely to become, affected.

There are three groups of questions to be considered in relation to the Johnson family: those relating to "cultural retardation" and associated conditions; those relating to the effects of "cultural deprivation" without regard to mental retardation; and those relating to individual differences.

Some Patterns of Cultural Retardation

Since, in many suspected cases of mental retardation, the child proves either to be too capable to be called retarded or to have other or additional bases for retardation, mental retardation associated with cultural deprivation would be given as a diagnosis only after other causative factors have been ruled out. Nevertheless, there are certain criteria which must be present for such a diagnosis to be assigned. Among these are a *mild* degree of retardation and evidence that the child does not differ drastically from the rest of his family in his general behavior. These two criteria seem to be met in some members of the Johnson family, but a clinic should make the diagnoses and determine specific treatment plans. For teaching purposes, it will be assumed that a multidisciplinary team confirms the assumptions made in these cases.

A common characteristic of families such as the Johnsons is that the younger children seem much brighter than the older. There are several possible reasons for this, a fairly obvious one being that the longer a child is exposed to a noxious environment, the greater the resulting damage is likely to be. Another possible reason might be the kinds of expectations of children at different ages. For example, the culturally deprived child is usually thrust into independence earlier than the middle-class child. Since independence is one

indication of adequacy, the poor child's greater independence would tend to enhance his apparent ability in early childhood. On the other hand, adequacy in school is one of the major measures of intelligence for the older child, and here the culturally deprived child is at a great disadvantage. A possible reason for the gradual decline of scores on intelligence tests as the culturally deprived child gets older may relate to the greater cultural bias of tests for older children. Vocabulary and experiential differences, motivation, quality of education, and a number of other factors tend to have an increasingly strong effect on test performance. Altogether, it is not surprising that children living in long-established poverty and hopelessness fall farther and farther behind their more favored age-mates.

The youngest Johnson child, Susie, seems quite normal, and Wayne seems to have developed rather normally except for possible petit mal seizures. Where reliable information can be obtained, early developmental histories of culturally deprived retarded children are often unremarkable. That this is not based only on faulty memory or deliberate or unconscious distortion is supported by the number of studies showing that such children reared under more propitious circumstances reach normal levels of intelligence.[1] In other words, many of these children are normal until the devastating environment makes them subnormal.

What the critical periods are for the development of various skills is an extremely complex problem, and one that is not likely to be definitively solved for many years to come. More and more evidence is piling up, however, to place the most critical period for the development of school-related skills generally in the preschool years. If Susie and Wayne are to be prevented from becoming retarded, immediate steps must be taken to alter the stultifying circumstances of their lives.

The family must be strengthened generally, but, for the youngest, special enrichment programs must be provided which can help to counteract some of the damaging aspects of their home and neighborhood. High quality day care, nursery schools, Head Start projects, and similar programs can stimulate development in the children prior to starting school and can help prepare them for constructive participation in school by minimizing some of the detrimental effects of the culture-school gap.

How much can be done for 6-year-old Roseann is not known, and efforts at prevention may not be quite so successful as for the preschool children. A pessimistic attitude, however, is certainly not warranted.

Considering her background, Roseann's behavior is not unusual for a first grader. Poor speech, an outgoing personality, and unfamiliarity with the

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[1] Skodak, M. and Skeels, H. M., "A Final Follow-up Study of 100 Adopted Children." *Journal of Genetic Psychology,* 1949, pp. 85-125.

structured activities of the classroom are frequently seen in the culturally deprived child in the early days of school. Spontaneity, unfortunately, is often lost or takes the form of undisciplined rebelliousness if the educational program continues to demand behavior which has little utility value at home and in the community, and if verdicts of inadequacy and failure are the usual outcomes of attempts to be an individual.

If Roseann is presently incapable of working at her grade level—and we do not yet know whether this is so—then a special class with a good program may be indicated. It is important that such diagnosis and placement be made early. If, as too often happens, her special needs are not recognized until she has undergone several years of chronic failure in a regular class, a special class may be unable to overcome the resulting negative self-concept and self-perpetuating expectations of failure.

Retarded people—like the culturally deprived—are usually oriented not toward achieving success, but toward avoiding failure. Imagine for a moment that a person of average intelligence is placed in a class of Einsteins. How long would he continue to try? How long would it take for the feeling of being a constant failure to penetrate beyond the activities of the classroom into other areas? So it could be with Roseann, unless she is placed in a benign environment, and so it probably is already with the older children. They, too, need to be studied carefully by a diagnostic clinic, not only to make or reject a diagnosis of retardation, but also to identify other problems, including the physical, educational, and emotional problems that are frequently present among both the retarded and the deprived.

Some Aspects of Cultural Department

A characteristic of culturally deprived families that is seen in this case is the apparent relationship between Mrs. Johnson and her husband. The husband's emphasis on masculinity, the wife's need to depend on her own family rather than on her husband for emotional support, and the poor communication between them and among all the members of the family are common themes. Much more must be learned about Mr. Johnson and about the marital relationship before treatment can be focused on this area. That it must be studied and treated is obvious, however, from the fact of his incestuous relationship with Nancy.

It is well documented that the poor tend to have more health problems than the general population.[2] In the Johnson family, we know that Jimmy and

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[2]Irelan, Lola M., "Health Practices of the Poor" [in] *Low-Income Life Styles.* Department of Health, Education, and Welfare, 1966, p. 51.

Wayne have serious conditions which require immediate medical attention. Quite possibly, Jane, too, needs medical as well as psychiatric attention.

We cannot assume that Mrs. Johnson's failure to obtain medical help implies rejection of Jimmy and Wayne or lack of concern. There are many other possible reasons for her not readily seeking medical advice. If she has to spend all day in line at a clinic, who will look after the baby? Will she have enough money to buy the prescriptions? She probably does not realize the possibly severe consequences that may result from Jimmy's ear trouble, much less that Wayne's peculiar spells may have serious consequences. She may have tried home remedies on Jimmy or consulted a druggist or neighbor, and concluded that she has done all she can or should do.

More basic, perhaps, may be a view of health or illness that is common among the poor. As one observer has put it, "When income is uncertain and not always enough to cover rent and food, 'health' is understandably likely to be defined as the ability to keep working."[3] Since school is unimportant to Mrs. Johnson, Jimmy's frequent absence is unimportant. The wage earner's illness warrants attention; other family members' illnesses must be more obviously dangerous to warrant the incurring of additional expense. Furthermore, Mrs. Johnson has probably had some unhappy experiences trying to obtain health services. The "red tape," impersonality, and long waiting lines are not readily faced by a person of limited energy, time, and self-confidence. A major social-psychological obstacle has been described by Irelan:

> "People at the bottom, sociologically sophisticated or not, know that wealthier, better educated people are likely to be more or less contemptuous of them. Worse, they sometimes adopt those attitudes toward themselves. And so is constructed one more stumbling block in the way of efficient health care for the poor.
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> "Awareness of social distance is probably one of the causes of distrust of physicians among low-income people. Definitely, the distrust of doctors is linked to low rates of participation in health programs. Feelings about social distance can also be discerned in the poor man's preference for consulting practitioners who are socially less distant from him than the physician.
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> "However, it is in clinic attendance and community program participation rather than in commerce with individual practitioners that the disaster of the poor man's seeing himself in this way is clearest. People who feel themselves poorly evaluated by clinic personnel are less cooperative patients and use clinics less.

[3] *Ibid* (p. 57).

They are less accessible to health information and education efforts of clinic personnel."[4]

Finally, the fatalistic attitude and feeling of powerlessness of the poor tend to reduce the need to take action. "If you're going to get sick, you're going to get sick, and there's nothing you can do about it." Thus we see exemplified the intertwining of educational deficiencies, health problems, personal philosophy, and intellectual functioning.

Need for Individual Diagnoses

Every one of the Johnson children should have a complete medical evaluation. None of them have had the routine medical care that many middle-class children have from the time of birth. For several of the children, a health examination would probably lead to further examination by other professionals such as psychologists, neurologists, and speech and hearing therapists. If a mental retardation clinic is accessible, Jane, Jimmy, and Roseann probably should be referred to it for the multidisciplinary service that such a clinic provides. There are now close to 250 mental retardation clinics across the country providing diagnosis, evaluation of a child's capacity for growth, development of a treatment plan, and followup care. Many clinics accept referrals from all types of professional personnel and self-referrals. Some accept referrals only from physicians.

NANCY: Although Nancy is not in the home at the present time, it is important that she not be left out of consideration. She is likely to come home for visits and after discharge from the institution, but, more importantly, her problem is integrally related to those of the other family members. One can speculate about the effects on Jane of her sister's behavior and its outcome; the other children, too, must have drawn some conclusions about her disappearance from the home and the reasons for it. Social workers know, on the basis of both theory and experience, the many far-reaching effects of separation, not only on the child who leaves but on the siblings, too. The fact that Nancy and some of her brothers and sisters are retarded does not alter the impact of separation on them, though it may increase the chances of their misinterpreting it (not that keen intelligence always prevents a child from making wildly irrational interpretations of such experiences).

Retardation may result, too, in less healthy defenses, so that these children may need even more help than normal children in dealing with

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[4]See footnote 2, page 57 (p. 59)

Nancy's circumstances. Cultural deprivation also seems to lead to weak and unconstructive defenses, with denial, rationalization, and projection the most frequently noted mechanisms. Consequently, it would be safe to assume that Nancy's experience will have effects on the other children, and that Mrs. Johnson is probably not able to deal wholesomely with them. If the worker is to help them, she must know what this experience means to each child. Not only the separation, but the sexual context, also has deep significance.

Strangely, perhaps, in view of the living conditions where privacy is seldom possible, the poor are often abysmally ignorant of the physiology and psychology of sex. Nancy's "fate" might well contribute much to unhealthy fantasies about the dangers of sex, the roles of men and women, etc. Certainly, the significance will be different for the boys and for the girls, and age and personality differences will contribute further to the personal nature of their responses. Obviously, then, the worker cannot help the Johnson children unless she knows what it means to each.

In addition, the agency should consider Nancy as a client, even though she is not living at home at the moment. In the first place, the agency's understanding of the family, of Nancy's place in it, both formerly and in the future, can very materially contribute to the adequacy of the diagnosis and treatment-training plan arrived at by the institution. Without a clear understanding of the situation from which Nancy came, and to which she will return after completing the training program, the institutional staff will be hampered in tailoring a program to fit her. True, Nancy is apparently capable enough to provide a good deal of information herself, but the very problems which caused her placement there can be expected to cause inadequacies in her rendition of her history.

Secondly, it is important that plans for periodic visits by Nancy to her home and by the family to the institution be made on the basis of a mutually understood division of responsibilities among the institution, the community agency, and the family. Plans for Nancy's discharge should not be left until the last minute, but should be an integral part of the total planning with the family. Until more is known about the relationship between Nancy and her mother, we cannot predict what will happen to Nancy's place in the family. In many instances, when a retarded child is admitted to an institution, his "place" disappears, and it becomes extremely difficult to reinstate him upon discharge. Generally speaking, such displacement is less common among the culturally deprived than among the middle class (possibly because of the difference in social stigma attached to retardation), but it is possible that Mrs. Johnson may, because of resentment toward Nancy, tend to separate Nancy from the family group.

A third consideration relating to Nancy is the matter of her baby. Here, too, another agency carries primary responsibility now, but it is possible that he may eventually be returned to Nancy, placing him within the purview of the family agency. There are two aspects of this child which relate to cultural retardation and which must be carefully assessed. One is the socio-cultural-intellectual background of his parents, and the other is the incestuous relationship between them.

A number of studies have shown that, generally, children born to culturally retarded parents have the potential for normal development (provided they are not organically damaged, of course). Skeels, Harms, and others have shown clearly, through a variety of studies, that when such children have been separated from their own families, they tend to reflect their foster or adoptive parents rather than their natural parents, and that *their* children continue to demonstrate normal or better ability (see footnote 1 p. 56). It is clear, then, that had Nancy not been involved in an incestuous relationship, the expectations for her baby, assuming that he has not suffered physically, would be within the normal range.

The incestuous relationship makes it another matter, however. When two unrelated people mate, the chances that both will have exactly the same defective genes are quite small. The more closely related the man and woman are, the greater are the chances of congruence. Plans for permanent placement (adoption or long-term foster family care) of Nancy's baby must wait until there has been adequate time for any severe defects to be manifested.

In short, there are many reasons for the welfare agency to maintain its concern for Nancy and her baby, even though other agencies have the primary responsibility for them at the present time. Failure to include her in study and planning may well lead to severe complications in the total family case later.

JANE: There are a number of factors which seem to be contributing to Jane's poor level of performance, only one of which is possible mental retardation. A possible factor is suggested by her tendency to daydream and her apparent isolation not only from her peers at school but also from the other members of her family. Through skillful diagnostic studies, a determination can be made as to whether Jane is emotionally disturbed and whether referral for psychiatric or other treatment is indicated.

The question of Jane's motivation must be considered in assessing her abilities. So far, the only picture we have of her role at home is that of "slavey," which would suggest that she sees herself as valuable only to the extent that she is helpful, and she seems to fall short of her mother's expectations even here.

To the extent that desire for achievement per se does not motivate Jane to put forth her best efforts, a psychological evaluation of Jane under usual

circumstances is likely to produce an underestimation of her ability. For example, instead of trying to figure out the rule that governs a sequence of numbers (a task often used in intelligence testing), it is much easier for her to shrug or giggle and say, "I don't know." If she doesn't try, she need not face the dismal feeling of another failure. Only if the reward for trying is big enough and real enough *to her* to make the risk of failure worthwhile is she likely to exert herself to the maximum. When Jane took the test, which resulted in a score of 61, she was probably not highly motivated.

The group test used in this case may fairly well reflect the kind of behavior to be expected from Jane on written examinations in general. It cannot be said, however, that such a test will result in a score that is necessarily a good index of how she would behave in other classroom situations, much less of her behavior outside of school.

Group tests should be used primarily for screening purposes with children receiving low scores referred for individual testing. For one thing, many group tests rely heavily on reading skill, thus penalizing children who cannot read at the expected grade level. Jane, at 13, apparently reads at about the second grade level, hardly advanced enough to make it possible for her to compete with most of the other children in the fifth grade. A meager vocabulary and very limited experiences also militate against an accurate assessment of nonschool-related abilities.

When individually tested under circumstances which take into account all of these factors—motivation, self-concept, experience, reading ability, vocabulary—Jane might score considerably higher.

In school, her performance was at about the level of an 8- or 9-year-old. Physically, she is either adolescent or preadolescent. Socially she may or may not be ready to develop an interest in boys. Because of the irrational fears often attached to people who are deviant, many neighbors may assume that Jane is already or will soon become sexually promiscuous—especially in view of Nancy's history. (This issue is discussed in greater detail in regard to the case of "Lucinda Parker.") In Jane's case, however, her withdrawn behavior and general immaturity would suggest that, though she could become the object of exploitation, she is at this time probably not much beyond the level of psychosexual development of most 8- to 10-year-old girls. In other social skills, she is likely to be deficient and will need many opportunities to learn. In setting up opportunities for her to learn, her proneness to failure and the damage that further failures can do should be kept in mind.

It is clear, then, that much needs to be learned about Jane if we are to be really helpful to her: physical, emotional, intellectual, and social factors must be thoroughly assessed.

JIMMY: A complete evaluation is needed not only of Jimmy's medical problems and their role in decreasing the efficiency of his intellectual processes, but also of the effects of his parents' destructive attitudes toward him. Cultural differences must not blind us to the similarities. If Jimmy came from a middle-class home and exhibited the kind of behavior he does, and had a history of a scornful father and an ambivalent mother, his need for help from a guidance clinic would be readily noted. The need should be no less clear because it exists in a generally deprived setting. Since, however, Jimmy's mother is not likely to respond appropriately to the traditional approach of a middle-class oriented clinic, some other resource must be found to provide a thorough evaluation. Then, on the basis of Jimmy's specific needs and strengths and the resources available in his family and community, a treatment approach can be worked out.

Scholastically, he is operating about 2 years behind his chronological age. Emotionally, he seems even younger. Socially, too, he behaves in some ways like a preschool child.

If Jimmy's intellectual ability were "normal," we would probably attribute his stealing to his emotional problems, some of the roots of which are not hard to find. We should not expect emotional and other factors to be any less operative because of his scholastic and possible mental retardation.

First of all, we do not expect any preschool age child to understand the general concept of private property—we expect to supervise him closely enough to prevent his taking what does not belong to him. Not until the first several years of school do most children mature enough to comprehend the general principle and to be able to control their behavior enough to resist temptation. By implication, then, a mental age of about 6 years or more is necessary for this comprehension.

Even with this degree of mental development, a child may steal because his need is so great that he cannot act on the basis of the rule. This great need might be very real—as in the case of a hungry child who steals food; or it might be neurotic, as when a child steals to meet some unsatisfied emotional need, such as for love, esteem, etc.

Occasionally, children may steal because, though they are bright enough to have learned the rule, they have never been taught it. In cases of severe neglect, a child may not be taught by his parent not to steal, and it may take longer than usual for him to learn. His siblings and peers are likely to teach him eventually unless emotional problems enter in. In some multiproblem families, stealing is overlooked if not condoned.

In Jimmy's case, there is nothing to suggest that he would not have been taught, and, at age 9, he should be able to understand the rule if his intelligence were normal. His scholastic retardation suggests that he may not be mentally

developed enough to understand, however, so that an evaluation of his stealing must await further diagnostic information. Regardless of his mental age, though, we should be concerned about his emotional state. There is not only his stealing but also his crying and throwing rocks to be considered, and it is quite possible that these problems are related.

The point is that *we should not glibly ascribe to deficient mental functioning the basis for all aberrant behavior.* If the defect is so severe as to preclude the child's understanding of his acts, that is one thing; much more frequently, however, emotional factors are at least as important as the mental. All such factors must be assessed in each case if we are to plan appropriately.

ROSEANN: So far, Roseann seems to be a fairly healthy child, emotionally and socially, though there is much we do not yet know about her. Her speech problem, as well as that of each of the other children, needs to be analyzed, and a more detailed study is needed of her mental and scholastic ability before further school plans are made for her. It is almost certain that she needs an enrichment program to overcome the handicap of her limited experiences, but we do not know whether her restlessness causes her to fall behind in reading, or whether her frustrations in reading are being taken out in physical activity—or both. A detailed diagnostic study is needed to help us know where and how to intervene.

Roseann should be given a thorough medical examination even though no physical problems are recognized now. Every effort should be made to correct defects in these children who already have so many handicaps. Any correction may be the one that puts the child over the line between almost certain failure and potential success.

WAYNE: This youngster obviously needs medical attention, even though his mother does not recognize his condition as being unusual. His behavior—brief loss of consciousness—is suggestive of petit mal epilepsy. Sometimes a child with petit mal will lose consciousness for so brief an instant that he gives the appearance of merely having hesitated in his action. In other cases, as with Wayne, the break is sometimes enough to cause him to briefly lose his orientation.

It is important for several reasons to have Wayne carefully evaluated and treated. Without treatment, his condition could become worse, so that he might develop grand mal seizures which would be much more of a handicap. Also, it is obvious that he could hurt himself more than he has done so far if he should lose consciousness at the wrong time.

In encouraging Mrs. Johnson to take Wayne to a clinic, it is important that her culturally-determined attitudes and ideas about health problems in

general be taken into account; but, in attempting to overcome her possible lack of conviction about the necessity of such a course of action, we must be careful not to overwhelm her by emphasizing the long-range possibilities of Wayne's condition. For some people, even well-educated people, there is still a social stigma attached to epilepsy as there is to syphilis and other "hush-hush" diseases—including mental retardation. Care must be taken that Mrs. Johnson is not overwhelmed by the recognition of this extra burden, which would be heavy enough if she had few other problems to deal with. The immediate concern should be to seek medical diagnosis and care and reduce present hazards. The caseworker will need to help Mrs. Johnson develop a more active approach to the family's health, partly by helping her solve the practical problems, partly by helping her change her attitudes toward medical services. Later, she may also need help in dealing with the attitudes of some members of the community once Wayne's condition is known to them.

In addition to medical attention, Wayne will need an assessment of his development so that suitable enrichment programs can be devised for him in order to prevent mental retardation.

SUSIE: The soundest approach to a prevention program for Susie is probably through educating her mother to better child-rearing methods. She seems to have been babied more than the other children, and has been allowed to cling to her bottle and get what she wants without speech longer than usual. We see no evidence in this family of the violent forms of punishment occasionally found in such homes. Rather, with Susie, at least, it seems to be a problem of slight overindulgence.

Any help that can be given Mrs. Johnson should benefit not only Susie but the whole family. At the present time, however, we do not know much about Mrs. Johnson's capacities as a homemaker and mother. There is evidence of the isolation of the children from Mrs. Johnson, especially the older children, with little understanding of them on her part. Nor do we know the condition in which the home is kept. Only on the basis of more knowledge can we develop a treatment plan.

PLAN FOR THE WHOLE FAMILY: It may be that the whole family's functioning can be improved by placing the younger children in a stimulating day care program and providing Mrs. Johnson with an opportunity to learn a skill and go to work. The belief that every child needs the care of his mother, regardless of the circumstances of the home, is being questioned. Skilled day care may provide stimulation and training needed to prepare impoverished children for more successful school careers and adult roles.

Furthermore, a job may encourage Mrs. Johnson toward a more optimistic approach to life. Her apathy, unless counteracted, can frustrate attempts to improve the lot of the children. Mrs. Johnson and her needs as an individual must also be of concern to the worker.

SUMMARY: Each member of the family, then, needs to be carefully diagnosed, preferably by a multidisciplinary team. Then, on the basis of all available information, a treatment plan needs to be determined which takes into account the needs and assets of each member.

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DHEW Publication No. (SRS) 72-23003 ● 1971